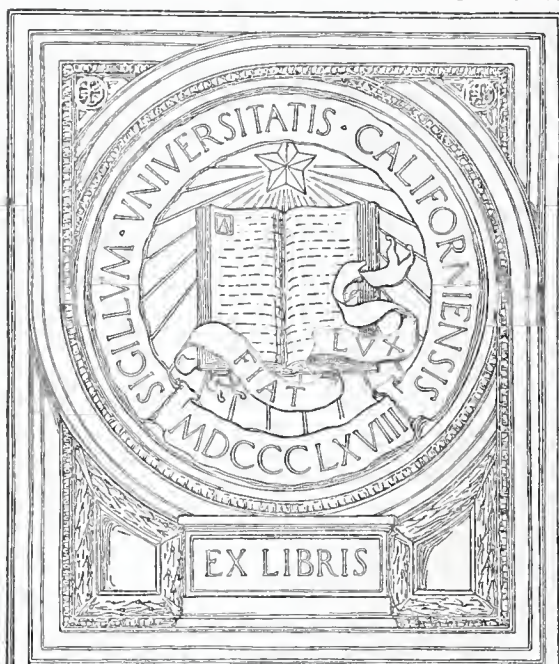



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SAM J. ALLBRIGHT, M. D.
Searcy
President
Arkansas Medical Society
1943-1944

The JOURNAL

OF THE ARKANSAS MEDICAL SOCIETY

PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. XL

LITTLE ROCK, ARKANSAS, JUNE, 1943

No. 1

PRESIDENT'S ADDRESS *

R. B. ROBINS, M. D.

It has been very charitable of you to permit me to serve as your president. The presidency of the Arkansas Medical Society is a great honor. It represents the most that the Arkansas Medical Society can do for any member and I want you to know that I deeply appreciate the confidence you have expressed in me. I am told that I should feel particularly complimented since I am the youngest physician who has ever served as president of this organization.

I hope that, during the year, I have not misrepresented you in any of my acts or utterances. I know that occasions have arisen at various times when there was not perfect agreement on issues. What I have done and said, I can truthfully tell you, was that which I thought was best for organized medicine as a whole. I beg your tolerance in any criticism that you may have.

These are very trying times for us when the world is being bathed in blood and tears. The winning of the war and the post-war world are the two thoughts that are uppermost in our minds today. The tide is turning daily in our favor as far as winning the war is concerned and our confidence is being strengthened more and more in victory. Medicine in America is very proud of its contribution to the effort since the contribution of medicine has been made without compulsion. We are proud that Arkansas has made a very creditable showing in contribution of physicians to the armed services. When our physicians have been declared available, they have shown their patriotism by immediately applying for commissions. I know of no instance where any physician in Arkansas has been brought before the bar of public opinion for failure to enlist and I do not believe that occasion will ever arise in the future. One-third of the effective practitioners of this country are now in service and we still have more doctors per thousand population in civilian life than other countries.

The medical profession will continue to do its part in and out of service. We are proud of the recognition given not long ago by Brigadier-General Lewis B. Hershey, Director of National Selective Service, when he said: "The doctors of America have contributed more to Selective Service without compensation than have the followers of any other vocation or occupation."

Many medical meetings have been cancelled, as you know. We had some discussion about cancelling this meeting and only holding a session of the House of Delegates. Finally we decided to hold this abbreviated convention of two days. I think it is very important to hold as many medical meetings during the war as we can, because our fellow physicians in service are looking to us, during their absence, to uphold the ideals of medicine and, again, the public is expecting us to keep ourselves informed so that we may be able to render the best service possible.

Our organization has an obligation to make all the effort possible to keep our membership acquainted with progress made in scientific medicine. All organized medical societies have, also, an increasingly important obligation, to my mind, in keeping the public informed as to what medicine is doing for the country under the American way of practicing medicine. If we want to preserve the American way of practice, we must continually keep the public informed regarding its advantages. Our Committee on Public Relations should be very active. The future of the practice of medicine in this country will be determined, to a large extent, I hope, by the medical societies and by the foresight of the leadership selected by medical societies. And so, I say again, I am very happy that we are meeting and I think that we have great cause for meeting.

I said in the beginning of this address that there were two thoughts uppermost in our minds—the winning of the war, first, and, second, the post-war America. I feel that this address would not be complete if some mention were not made of the recent report of the National Resources

* Presented to the Sixty-eighth Annual Session, Arkansas Medical Society, Little Rock, April 19, 1943.

Planning Board in which a plan of social security from "the womb to the tomb" was presented. . . .

We believe that we are in this war to stop totalitarianism. The object of totalitarian governments was to conquer the world and impose their system on it. The fundamental basis of totalitarian government is to make the state supreme over the individual. The state under that system of government takes care of the individual. And, in turn, the individual becomes completely dependent on the state and the state acquires complete power over him.

Let us not forget that Bismarck introduced a "Beveridge Plan" in Germany many years ago and it finally resulted in Hitlerism. Under it the state entered more and more into private enterprise and it finally began to swallow it. The result was that management and labor were entirely dependent on the government.

Surely, we are not ready in this country to regiment our people, our physicians and our hospitals in a politically controlled medical bureaucracy.

There are those who dream of a post-war world in which there is freedom from want—a Utopia. If we are to have security against unemployment, old age, accident, sickness and all the other hazards of life which will provide a freedom from want, whether or not the individual works, I would like to ask this question: "What incentive will there be to work?"

Yes, my friends, new orders of life are arising in which the drift seems to be from independence toward dependence. You, as intelligent, thinking men and women, are being challenged to decide as to whether or not we are going to trade freedom for security.

My plea with you today, my fellow physicians, is to exert your privileges as citizens more than you have ever done before.

Physicians are more or less community leaders and can have, if they become interested, a great influence on public issues that arise. I think that it behooves the doctor to take more and more interest in political matters, because government is entering more and more into the lives of people. We are conscious of the presence of government at every turn we make these days. This consciousness has progressively increased during the past ten years. The type of men who occupy places in the legislature, in Congress, and in administrative positions of government is certainly a matter that should concern the doctor. I say to you that you have great poten-

tial opportunities to mold public opinion if you will only use them.

In conclusion, may I beg of each one of you to devote some of your time, your energy and your money to the common good.

CORRESPONDENCE

Arkansas Tuberculosis Sanatorium
May 20, 1943.

To the Editor:

I am enclosing a copy of House Bill No. 103 which provides for the administration of pneumothorax to patients who are away from the sanatorium and who are not able to pay for the same.

We have a list of physicians here at the sanatorium in various parts of Arkansas who give pneumothorax, but it is entirely possible that some physicians who are prepared to give pneumothorax might have been overlooked.

I will be pleased if you will put what you would consider the proper notice in the next issue of the Arkansas Medical Journal, requesting any physicians who are prepared and who are willing to give pneumothorax to communicate with me.

Yours sincerely,
J. D. Riley, Superintendent.

Be It Enacted by the General Assembly of the State of Arkansas:

Section 1. Where a patient has been certified by the Superintendent of the two Tuberculosis Sanatoriums as requiring treatment known as pneumothorax, and when it is safe for such patient to remain at home, that from the funds credited to the State Welfare Fund, the sum of \$15,000.00 shall be set aside, for the purpose of paying the fees of physicians for administering pneumothorax treatments to patients who have been certified to said physicians by the Superintendent of either of the State Tuberculosis Sanatoriums, provided that before the patient can receive such pneumothorax treatments as provided herein, the County Judge of the county in which the patient or patients reside shall certify that such patient or patients are not financially able to pay for said treatment, and that such pneumothorax treatments shall be paid as provided in this Act, and provided further the fees for any physician shall not exceed the sum of \$3.00 for each pneumothorax treatment administered to any patient.

Section 2. It shall be the duty of the Superintendent the Booneville Tuberculosis Sanatorium to certify one or more competent physicians residing in sections of the State deemed necessary for him, provided the physicians are properly trained for said purposes, where said pneumothorax equipment is located, for the purpose of administering such treatment.

Section 3. The fees of said physicians shall be audited by the Superintendent of the Sanatoriums, and shall be paid as are other obligations of the State.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

WHY SIFT the population for previously undiagnosed tuberculosis? The answer usually given points first to the benefits conferred on the individual whose tuberculosis is discovered early and treated promptly, next emphasizes the necessity for protecting public health through segregation of bacillary cases, and concludes with the sound economic principle of saving the money and resources of everyone concerned. Now that war demands threaten existing treatment facilities and, by the same token, might become reasons advanced for curtailing mass surveys, an argument is advanced that says the continued finding of cases in excess of available bed capacity is the best possible lever to use, not merely to maintain present beds, but to secure new ones. There seems to be no good excuse for slackening off our attack on the total tuberculosis problem simply because the bed problem has become acute. The clear indication is that if we blindly allow ourselves the luxury of finding less tuberculosis now, we most certainly shall find more tuberculosis later on.

TIME FOR MORE TUBERCULOSIS CASE FINDING—NOT LESS!

Case finding is the major activity of the Department of Health in New York City in the prosecution of its campaign to control tuberculosis.

In consideration of the known overcrowding in institutions in the city and the number of cases at home but in need of some form of institutional care, it is estimated that New York City needs 3,000 additional beds. As important as adequate beds may be in providing treatment or isolation for the active or infectious case, there is no cause to delay or curtail an aggressive case-finding program. That program during the past is responsible in large part for the beds now available and the present deficiency will only be met if there is a demonstrated need for them.

We must educate the lay public to a realization of the tuberculosis problem and how to solve it. People known to have been exposed must be reached, apparently healthy citizens must be screened and budget-making officials must be impressed and their support secured. Among our own professional groups nurses and physicians have to be won over, in many instances, to a sympathetic consideration of the problem and the employment of modern methods of discovery. Fortunately, although some older physicians remain unconvinced, medical students and

younger doctors are being exposed to up-to-date teaching that is effective.

The basic program in case finding must start with a search for disease among those in close contact with an open case. This problem is particularly important where congested housing and similar opportunities for close contact exist. In order to make existing clinic facilities available for an increasing load of screening apparently healthy people drawn from groups of known high tuberculosis incidence, it has been necessary to develop a system that will do so without decreasing the effectiveness of the search among contacts.

Changes resulting in a saving of about 6,000 man-hours of labor per year have been introduced, without any apparent loss of efficiency in examining contacts. Previously, each new case admitted had the regulation history form completed, was given a physical examination; children were tuberculin tested using 0.1 and 1.0 mg. O.T. (Mantoux). Reactors were X-rayed, as were all adults above the age of fifteen. Rarely did more than 5-10 per cent reveal findings sufficient to call for further study.

The new procedure replaces the regular history with a 5 x 8 inch card providing space for

contact history and presenting symptoms. A physician sees each case briefly. Complete examination is made only in those rare cases warranted by a suggestive history. Most cases proceed directly to the X-ray department. If the radiograph is negative, further examination is not done unless the individual is over 10 years of age and recently exposed to open tuberculosis. Those with suspicious or manifest evidence of disease by radiograph are called back to the clinic for complete history, physical examination and other investigation and are supervised appropriately. Children between the ages of 3 and 10 with normal X-ray findings are not routinely supervised until they pass the latter age and then in accordance with their continued exposure to a bacillary case.

The application of these principles has resulted in reduction of the case-load carried in all clinics, permitting more attention to the significant cases and extending the use of clinic facilities in reaching others. There has been noted improved staff morale and greater satisfaction among the patients.

The mass survey, as a method of case finding, has been developed according to well conceived ideas based on demonstrated mortality and morbidity figures. Tuberculosis is more prevalent in tenement house areas and among the poor and unemployed than among those of better social or economic surroundings. In New York City the major problem in tuberculosis exists among the colored population. The mass survey of the colored of all ages is indicated.

Information gained from mass surveys in New York City has made it possible to indicate clearly where to expect most tuberculosis by age, sex, color and economic groupings. Highest yield came from a group of homeless and non-settled males, with 54 cases per 1,000, while the lowest was only one significant case per 1,000 among the pupils of a high school.

Cooperating with the Army since the very beginning of the draft in 1940, the Department of Health first carried the entire responsibility for personnel and X-ray examinations, soon shifted to the exclusive function of following up all resident men rejected at the area Induction Centres because of suspected pulmonary tuberculosis. This has given opportunity for seeing that proper supervision is provided in each case, and has been marked by close cooperation with and by the local draft boards. If a man fails to report after the induction board examination, a

letter to the chairman of the board results in the issuance of an order to the delinquent to appear.

Today, national existence depends on national defense and this, in turn, on national fitness. One of the most serious problems confronting public health administrators is tuberculosis, a most communicable malady and one that invariably increases during periods of war. The safest defense, so far as tuberculosis is concerned, is to find the cases now and get them under supervision so that there will be less opportunity for advanced disease to develop and, thereby, less change for the further spread of infection to others.

There are thousands of men and women now returning to jobs in industry after months or years of inactivity because of tuberculosis or because of other reasons such as unemployment. Sudden return to regular work may cause a relapse or stimulate latent lesions to flare up. Increased income, with increased recreational activities and irregular hours supplementing heavier occupational demands, may upset the balance in favor of tuberculosis. Therefore, it is of the utmost importance that case-finding programs be expanded at this time.

Summary

Case finding is the basis of tuberculosis control in the program of the New York City Department of Health. Three major efforts in case finding have been presented. Through these sources 799,659 persons were examined between 1933-40 with the result that 37,339, or 5 per cent, were found to have significant lesions.

In order to speed up the program, many of the previously standardized procedures were greatly simplified, permitting greater emphasis on the important contacts and cases rather than to scatter efforts equally among all patients admitted, a large majority of whom are in no practical need of intensive supervision. The mass survey principle has been applied to the district clinic.

It is the policy of the Department to intensify its case-finding program regardless of the availability of beds for all cases discovered.

There is an indicated need for more mass education of the public about the facts of tuberculosis. The undergraduate medical student and nurse need more education in this field, and the practicing physician, if thoroughly interested, could contribute more in the control program than is the experience at this time.

Case Finding in New York City, Herbert R. Edwards, M. D., *American Review of Tuberculosis*, March, 1943.

THE JOURNAL

OF THE

ARKANSAS MEDICAL SOCIETY

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W. R. BROOKSHER, M. D., Editor
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EDITORIALS

OUR PRESIDENT

Sam J. Allbright, Searcy, installed as President of the Arkansas Medical Society in Little Rock, April 20th, was born near Harrison, Arkansas, October 23, 1885. He attended the schools in the vicinity of his home and Valley Springs Academy. For several years he taught in the schools of Boone and Searcy counties and entered the University of Arkansas School of Medicine in 1907, missing two terms to graduate in 1913.

He first practiced at Bellefonte, Boone County, for three years, affiliating with the Boone County Medical Society in 1913 and serving that society as president for one term during his residence in the county. Moving to White County in 1916, he later located at Searcy in 1923. In the White County Medical Society he has served as president several times and is the present secretary. Since 1913, when he first attended a session of the Arkansas Medical Society, he has missed but two annual sessions. In the state society, he has served two terms as councilor and has twice been a vice-president.

He served two terms as a member of the State Medical Board of the Arkansas Medical Society, during four years of which he was the secretary. He is a fellow of the American Medical Association and a member of the Southern Medical Association. In 1922 and in 1928 he took special post-graduate work in New Orleans. He is a Mason and a member of the Methodist Church, of which body he is also a member of the Board of Stewards. He has two children, a daughter, and a son who is now in military service on the African front.

A long period of loyal service to organized medicine during which he has ever been found in the forefront for advancement of the ideals and aims of the medical profession; a familiarity with the organization of the profession in Arkansas from actual service as a county, district and state officer; years of active work on various committees, well fit President Allbright for guidance of the affairs of the Society in the present period of change.

COMMUNIQUE

To the Editor:

Here is a tune I dished up between latrine inspections. It has received more acclaim than it deserves. You will note that the words embody the mission of the medical corps and the spirit of the prayer of Maimonides (500 B. C.). Try it on your flute.

I have been on several stations in the northwest and have become fairly well acquainted with the Rocky Mountains. I am trying to buy a setting of eagle eggs with the view of starting an eagle hatchery in the area of Mountainburg after the war.

Case report:

One of our cavalrymen was brought in a few days ago accused of making improper advances to his horse. Our psychiatrist asked him if the horse was male or female. He replied: "Doc, it was a female. What do you think I am, a queer?"

Sending The Journal is a fine gesture and it is read by the entire staff here, even though they have no interest in Arkansas.

I am fixing to make another trip but keep sending The Journal to Hill Field. The folks here will forward it.

Sincerely,
Hollis H. Buckelew,
Captain, M. C.,
Hill Field, Utah.

PROCEEDINGS OF SOCIETIES

The Pulaski County Medical Society was addressed May 3rd by Charles Winkler on "The Rickettsial Diseases."

Elizabeth Fletcher, Secretary.

The Ouachita County Medical Society met in regular monthly session May 6th at the Camden Hospital. The program consisted of the following medical motion pictures: "Syphilis," and "Athletic Injuries."

R. B. Robins, Secretary.

Howard-Pike County Medical Society has elected the following officers: President, T. F. Alford, Murfreesboro; Vice-President, J. S. Hopkins, Nashville, and Secretary-Treasurer, M. D. Duncan, Murfreesboro.

COMMUNIQUE *

"I can tell you this—that we are living quite well and enjoying life as well as one could expect to away from home. We have good food and so far plenty of it. The officers of our organization are living in a hotel—not the kind you are used to but at least it makes for some personal comfort. In the hotel we have established a lounge and a bar and are now having dances there just about every week-end. Our C. O. believes in such relaxation for the officers—and it is well that he does since only just now have our men had any break from constant work, day and night. And that break will be short, no doubt. I have been fortunate in the officers of my own group—that is, medical, dental, administrative, in that they go ahead with their work and I have largely become administrator only, although often decisions have to be made where my public health knowledge comes in very handy. Was on a trip about three weeks ago and saw much country reminding me of Arkansas, New Mexico, Arizona and California. Olive and almond groves, vineyards, wineries, fields of vegetables, desert, mountains, snow-capped and barren, cork forests, camel caravans, and the ever-present burros, and of course, natives, men, fatimas, and children—and what an assortment they are, black, white, brown and all intermediate shades of black. Straw-thatched huts, and substantial adobe and stucco houses. I have not the power of description to tell you of these sights. And yes, for a large part of the area there are many

storks—do not know if that bird is responsible for so many chillun around or not, but I got a snap shot of one perched atop a straw-thatched hut—did not look in the hut to see whether old stork had made a call there or not. There are many cattle, hogs, and many sheep and goats. Leather products are one of the principal industries of this section * * * and let me say to you that it is my sincere hope to be back among you one of these days and I hope not too far away."

PERSONALS AND NEWS ITEMS

J. W. Branch, Hope, now taking special work in tropical medicine, has been promoted to lieutenant-colonel.

Jos. H. Sanderlin, Little Rock, now on duty as executive officer, Wm. Beaumont General Hospital, El Paso, has been promoted to lieutenant-colonel.

J. S. Miller has moved from Parkin to Wynne.

BORN—On April 30th, a son, to Dr. and Mrs. (Dr.) B. E. Pickett, Jr., formerly of Conway, now located at Carrizo Springs, Texas.

Dan H. Autry, Little Rock, now stationed at Camp Robinson, has been promoted to lieutenant-colonel.

J. B. Futrell, Rector, now serving overseas, has been promoted to major.

Governor Adkins has reappointed R. J. Haley, Jr., Paragould; Robert Hood, Russellville, and L. J. Kosminsky, Texarkana, members of the State Medical Board of the Arkansas Medical Society.

Major Sam Phillips, Little Rock, is now on duty at Winter General Hospital, Topeka, Kansas.

Lt. R. E. Schirmer, Fort Smith, has been transferred from Camp Chaffee to the 1856th Service Unit, Fort Crockett, Texas.

Majors Wm. B. Harrell, Little Rock, and Warren S. Riley, El Dorado, are now on duty with the 210th General Hospital overseas.

Maj. J. K. Donaldson, Little Rock, has completed the course at the Medical Field Service School, Carlisle Barracks, Pennsylvania.

* Extracts of a letter from Lt. Col. A. M. Washburn, Little Rock, now overseas.

OBITUARY

LYLE GORDON YOUNG, age 42 years, died suddenly at his home in Van Buren April 19th. Born in Chicago, he graduated from the Kansas City College of Medicine and Surgery in 1925 and practiced at Decatur before coming to Van Buren in 1929. He had served the Crawford County Medical Society as secretary. Surviving him is his wife, Mrs. Margaret Kilner Young.

LEONARD R. ELLIS, age 68 years, Hot Springs National Park, died May 10th. Born in Tuscaloosa, Alabama, he graduated from Vanderbilt University School of Medicine in 1899 after preliminary education in the public schools and at Bethel College. He was a member of the Masonic bodies, the Sahara Temple, A. A. O. N. M. S., of the Royal Order of Jesters, of the National Sojourners and of the Sigma Alpha Epsilon fraternity. For over 45 years he had been a member of the Benevolent and Protective Order of Elks, having twice served the local lodge as exalted ruler, and had been a district deputy exalted ruler, a member of the Grand Lodge and state president of the Elks organization. He served in the Spanish-American War with General Pershing in the Mexican expedition of 1915-16 and in World War I, retiring from that service with the rank of colonel. For more than 20 years he was chairman of the Federal Registration Board at Hot Springs National Park. He was division surgeon for the Missouri Pacific Railroad and for the Rock Island Lines. In medical society affairs, he had been most active serving as president of the Garland County Medical Society and as a member of the State Medical Board of the Arkansas Medical Society. In addition to his membership in the Garland County Medical Society and in the Arkansas Medical Society, he was a Fellow of the American Medical Association and of the American College of Surgeons. Surviving relatives are his wife, a son and a daughter.

COMMUNIQUE

April 20, 1943.

To the Editor:

Since leaving Little Rock I have been transferred around in the Army quite a bit and consequently have failed to receive The Journal of The Arkansas Medical Society in over a year.

It is my understanding that the Pulaski County Medical Society will pay the State membership assessments for members in the armed forces. If this is incorrect please bill me for same at the above address.

Major Warren S. Riley, formerly of El Dorado, is also a member of this organization now and would like to report change of address. As you probably know the two of us left Washington with the 218th General Hospital but this organization was disbanded recently and we were transferred to the 210th. At present we are running about 1,000 beds and expect to expand soon. Warren is on the Medical Service and I am on the Surgical Service. We both like it fine here but after a couple of years you naturally get a little homesick for some cool weather.

With the kindest of personal regards, I remain,

Sincerely yours,

William B. Harrell,
Major, M. C., A. U. S.

COMMUNIQUE

May 11, 1943.

To the Editor:

I received my April issue of The Journal today and enjoyed it very much. It was forwarded to me from Salt Lake after making the round of nearly all the Army Air Bases in Texas.

We in the Service appreciate getting The Journal and always read it carefully from cover to cover.

Please make the correction on your mailing list and send me the May issue.

Sincerely,

James G. Martindale, Capt. M. C.
Chief of Surgical Service Station
Hospital Army Air Base
Dyersburg, Tennessee.

PROCEEDINGS SIXTY-EIGHTH ANNUAL SESSION ARKANSAS MEDICAL SOCIETY

HOTEL MARION, LITTLE ROCK, ARKANSAS

April 19th and 20th, 1942

FIRST SESSION, HOUSE OF DELEGATES

The meeting was called to order at 9:30 A. M. by President Robins.

The Credentials Committee (R. R. Kirkpatrick, J. F. John and W. R. Brooksher) reported that the credentials of the delegates present had been examined, found correct, and that a quorum was present.

The Secretary called the roll of the delegates. The following delegates and county society members seated as delegates by action of the House of Delegates were present:

BOONE—J. G. Gladden; BRADLEY—W. J. Hunt; CARROLL—D. K. McCurry; CHICOT—J. H. Burge; CRAIGHEAD-POINSETT—J. H. McCurry; CRAWFORD—S. D. Kirkland; CROSS—J. S. Miller; FRANKLIN—W. C. Porter; GARLAND—H. King Wade, Geo. B. Fletcher, W. T. Wootton; GREENE—Robert Haley; HOT SPRING—H. L. Brown; INDEPENDENCE—W. J. Ketz; JEFFERSON—Fred Hames; JOHNSON—Earle H. Hunt; LAWRENCE—J. C. Land; LINCOLN—C. W. Dixon; LONOKE—S. S. Beaty; MILLER—R. R. Kirkpatrick; MONROE—E. D. McKnight; OUACHITA—S. A. Thompson; PHILLIPS—J. T. Herron; POPE-YELL—A. B. Tate; PULASKI—Alan Cazort, S. C. Fulmer, Hoyt R. Allen, Fred W. Harris, M. J. Kilbury, G. W. Reagan; RANDOLPH—J. R. Loftis; SALINE—L. J. Harrell; SEARCY—J. O. Leslie; SEBASTIAN—I. F. Jones, S. J. Wolferman; UNION—A. D. Cathey, P. H. Muse; WHITE—G. C. Burton.

Other members of the House of Delegates present were:

President Robins, President-Elect Allbright, Vice-Presidents R. C. Dickinson, L. G. Martin, and S. A. Drennen; Councilors F. H. Jones, L. T. Evans, J. O. Rush, S. W. Douglas, B. L. Moore, Geo. B. Fletcher, Jos. F. Shuffield, J. F. John, and Clyde McNeil; Past-Presidents E. E. Barlow, A. S. Buchanan, E. F. Ellis, H. Fay H. Jones, L. J. Kosminsky, M. E. McCaskill, W. H. Mock, M. L. Norwood, D. A. Rhinehart, and H. T. Smith; Treasurer Paul L. Mahoney, and Secretary W. R. Brooksher.

By motion (Rush-Ketz) the minutes of the 67th annual session as published in the June, 1942, issue of The Journal of the Arkansas Medical Society were adopted as correct.

President Robins appointed as Reference Committee: S. J. Wolferman, E. D. McKnight and S. A. Thompson.

President Robins appointed as Committee on Courtesy Resolutions: H. T. Smith and L. T. Evans.

R. C. Dickinson took the chair.

President Robins delivered the President's Address to the House of Delegates.

It has been a pleasure to serve as the president of this fine organization. I only wish that my service could have been performed with more energy and more ability. There have been certain handicaps during the year due to war conditions.

I am happy that it has been my privilege to visit meetings in most sections of the state and I have been pleased to note a very great interest in organized medicine wherever I have gone. There has been a great manifestation of hospitality and a great spirit of co-operation shown by the members of the Arkansas Medical Society in every section where we have met.

I want to take this occasion to thank all the committee chairmen and committee members of the various committees of this organization for their splendid efforts the past year. I wish that time would permit calling the names of a host of men in the Arkansas Medical Society who deserve recognition for their fine work. I do want to take time to say to you that we, the members of the Arkansas Medical Society, owe a debt of gratitude, especially to two men of this Society, for their faithful, unselfish and untiring efforts in our behalf. These gentlemen are Dr. W. R. Brooksher, our efficient Secretary-Editor, and Dr. Joe Shuffield, our marvelous legislative chairman.

Last year you expressed your will that committee reports should be limited to ten minutes. I feel that you would likewise not care to have a lengthy address from the president and so I am going to make my remarks very brief. There are several matters which I would like to discuss with you.

First, I would like to propose a change in the By-Laws of our Constitution which has to do with the election of our President. Under the present Constitution the Nominating Committee must present the names of three members for the office of President-Elect. Because of this provision, we have observed on a number of occasions that members, whose names have been presented, have been embarrassed and sometimes provoked. We know that many times a third name has been presented when the individual had no desire or aspiration to be President. It seems to me that this provision should be amended so that two or more names may be presented by the Nominating Committee. It must be remembered, also, that nominations can always be made from the floor.

There is another slight change in the Constitution which should be made, but it is a very minor one. Last year an amendment was adopted which made the President-Elect a member of the Council. Section 2, Chapter VI of the By-Laws now reads: "The President-Elect shall be a member ex-officio of the Council. . . ." the word "ex-officio" should be deleted from this sentence.

There is another matter which I would like to bring up for your consideration and discussion. You know that there has been a great deal of discussion regarding

our two dollar annual registration fee. There was some talk during the last Legislature of repealing this law. In his message last year, my predecessor Dr. Jones, recommended that the Board of Medical Examiners employ an executive secretary. This was a very fine suggestion. If we are to keep this annual registration fee, then we should make effective use of it. It seems to me that an office should be maintained by this Board in the State Capitol in charge of an executive secretary.

The executive secretary should be a man with some legal ability so that he might be more effective in promoting prosecutions of any violations of our medical practice acts. The members of the board are all busy practitioners of medicine and they do not have the time to devote to such matters. It might also be possible for the Arkansas Medical Society to combine with the Board in employing this same individual to represent us as our legal counsel. I ask your consideration of this recommendation.

You will note some very fine suggestions made by the various committees. I want to call your particular attention to the following ones: The recommendation of the Committee on Syphilis that we sponsor a law requiring premarital examinations which will include tests for venereal diseases; the recommendation of the Committee on Medical Economics "that the Arkansas Medical Society go on record against any plan for insurance or group medicine that would in any way jeopardize independent medicine"; and, I am particularly impressed with the good possibilities of the recommendation of the Committee on Public Relations in which it is suggested that highway signboards be used to carry terse messages from the Arkansas Medical Society regarding matters of medicine of public interest. In addition to carrying scientific medical messages to the public it will afford a splendid means of carrying terse messages on medico-social and medico-economic matters.

The Mental Hygiene Committee has made a suggestion which appeals to me and which I wish to endorse before it is presented to you by them. It is suggested that a Medical Advisory Committee, consisting of the President, Secretary, Chairman of the Council and two Past-Presidents, be appointed as a consulting committee to work with the Governor and other constituted legal authorities in all medical matters in connection with our state institutions which are concerned with the rendering of medical service to the people of Arkansas. I commend this suggestion to you, because I think that such a committee could render a very great service.

There is a final matter which I desire to bring to your attention. It has to do with a suggestion that an office be established in Washington to represent the medical profession of this country. So much is happening in Washington these days that involves our profession that it seems very necessary that we have adequate representation there. Dentistry has such an office in Washington. The American Hospital Association has such an office. Only last week I had a letter from one of our own senators in which he asked to be kept informed about our attitude toward medical issues.

How and by whom such an office should be established is the question to be decided. The American Medical Association, since its wallop by the Supreme Court and because of its fear of additional taxes, seems to be shy. It might be that our National Physicians' Committee could handle this matter. I have a letter from the National Conference on Medical Service asking that I bring this to your attention. It seems that this proposal deserves study and I am presenting it to you

and to the Reference Committee so that you may instruct your delegates to the American Medical Association as you see fit.

Gentlemen, this concludes my message to you.

President Robins returned to the chair and the Committees of the Society reported in order, each report being referred to the Reference Committee.

COMMITTEE ON SCIENTIFIC WORK

The Committee on Scientific Work has experienced considerable difficulty in presenting the 1943 program. It is, however, confident, that the scientific papers to be presented will prove highly interesting and informative.

H. King Wade, Chairman,
Hot Springs National Park
W. R. Brooksher, Fort Smith
†Euclid M. Smith,
Hot Springs National Park
†Joe H. Sanderlin, Little Rock

REPORT OF THE COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

The Committee on Health and Public Instruction desires to make its report on health conditions in Arkansas during the past year.

There was no unusual incidence of any particular disease, with the exception of poliomyelitis. In 1942, 151 cases were reported as against 59 cases in 1941. Syphilis reports increased, due rather to better case finding than to any increase of the disease in the state. Reports indicated a decrease in whooping cough, septic sore throat, scarlet fever, diphtheria, and measles as compared with 1941. Pulmonary tuberculosis remained about the same. There was an increase in the number of cases of tularemia, 104 cases being reported in 1942 as against 97 in 1941. Typhoid, pneumonia, malaria, and undulant fever showed some decrease in 1942 as compared with the previous year.

The responsibilities of the State Health Department increased during the past year to an unprecedented level, due largely to the demands of the Army and war industries for the control of communicable diseases in and around defense areas. The Department has been handicapped because of the loss of trained personnel. Professional and technical help cannot be replaced and many areas of the state which were previously given public health service are now entirely without. Concentration is made on the control of communicable diseases, paying particular attention to milk control work, and the handling and preparation of food.

A great amount of planning and organization has taken place in regard to emergency medical service for civilian defense, and it is felt that Arkansas is well organized for any emergency that might arise because of enemy attack or sabotage.

Because of the loss of so many physicians and other health workers to the armed forces, we urge the remaining professional people of the state to always be on the alert for communicable diseases and report them to the State Health Department immediately—if necessary, by telephone.

Conditions brought about by the war try everyone's sense of responsibility, and only through cooperative

action will we be able to deal with any outbreak of epidemics.

W. B. Grayson, Chairman, Little Rock
Byron L. Robinson, Little Rock
J. Harry Hayes, Little Rock
M. C. Crandall, Wilmot
R. M. Eubanks, Little Rock
Hoyt R. Allen, Little Rock

Dr. Grayson briefly discussed the proposed plan to provide for obstetric, pediatric and hospital care for the wives and infants of enlisted men.

REPORT OF COMMITTEE ON PUBLIC RELATIONS

Your Committee on Public Relations submits the following report:

The only contact the Arkansas Medical Society maintains with the public, at this time, is through the articles, ably and laboriously prepared by our Secretary, and published by a majority of the newspapers throughout the state. Your Committee recommends that this contact be continued.

Your Committee thinks the time has come when some effort should be put forth by the Arkansas Medical Society to measurably counteract the pernicious radio and newspaper sales pressure so conducive to self-nostrum medication, and at the same time to put the seal of the Arkansas Medical Society on such procedures as may safeguard the health of our people.

Your Committee recommends that this be done in as dignified a manner as is compatible with deliverance of any public utterance. We, therefore, recommend the following method be used to get our messages to the public:

That the several county medical societies comprising the Arkansas Medical Society be authorized and requested to undertake, at their individual expense, the erection of roadside signboards at or near the entrance of highways to cities or towns;

That said signboards be of uniform size (possibly 3x4 or 4x5 feet) and carrying a terse, pertinent message.

No expense is to accrue to the Arkansas Medical Society, though jurisdiction over all messages displayed is to remain in the parent organization.

No wording other than the approved message is to appear on the board, except the signature—"Arkansas Medical Society," which will be at the bottom of each and all messages.

The approved messages may be changed or rotated at the will of the individual county society, monthly, quarterly, semi-annually, or otherwise.

It is suggested that messages may be printed on plywood or wallboard and attached to the permanent outdoor sign in order to facilitate changes.

Messages should be terse in order to be easily read.

Your Committee herewith submits a few approved messages. Others may be submitted by the several county societies for approval by the Public Relations Committee representing the Arkansas Medical Society.

Your Committee further suggests that these messages may also be used by the several county societies as display cards in the various newspapers of the state.

The following messages are suggested as being terse and appropriate:

THERE IS NO DISGRACE IN HAVING CANCER, THE DISGRACE IS IN THE CRIMINAL NEGLECT OF PROMPT DIAGNOSIS AND TREATMENT WHILE IT IS CURABLE.

ARKANSAS MEDICAL SOCIETY
WHY GAMBLE WITH YOUR CHILD'S LIFE? VACCINES ARE HARMLESS AND WILL PREVENT SMALL-POX, SCARLET FEVER, DIPHTHERIA, WHOOPING COUGH, TYPHOID AND OTHER DISEASES.

ARKANSAS MEDICAL SOCIETY
TUBERCULOSIS IS STILL RAMPANT. PARENTS OFTEN DELAY PROPER EXAMINATION OF CHILD WITH COUGH TILL DISEASE IS FAR ADVANCED.

ARKANSAS MEDICAL SOCIETY
MOST CHILDREN'S DISEASES START WITH A SNIFFLING COLD. DON'T SEND YOUR CHILD BACK TO SCHOOL TILL SURE HE WILL NOT SPREAD DISEASE.

ARKANSAS MEDICAL SOCIETY
DOCTORS ORGANIZE IN ORDER TO PROTECT THE PUBLIC FROM UNEDUCATED AND UNSCRUPULOUS MEN WHO VALUE YOUR DOLLAR ABOVE YOUR HEALTH OR LIFE.

ARKANSAS MEDICAL SOCIETY
WHY PAY A DOLLAR FOR A NICKLE'S WORTH OF MEDICINE BECAUSE IT HAS BEEN PATENTED? BY GUESSING IT WILL CURE, YOU MAY LOSE VALUABLE TIME.

ARKANSAS MEDICAL SOCIETY
YOU BET YOUR CHILD'S LIFE AGAINST A COUPLE DOLLARS WHEN YOU GIVE LAXATIVES BEFORE YOU KNOW CAUSE OF STOMACHACHE.

ARKANSAS MEDICAL SOCIETY
CLOSE YOUR ANNUAL HEALTH BOOK WITH A COMPLETE AUDIT OF HEART, BLOOD VESSELS AND KIDNEYS. PREVENTION IS BETTER THAN CURE.

ARKANSAS MEDICAL SOCIETY
BE SURE CHILDBIRTH DAMAGES ARE PROMPTLY AND EFFICIENTLY REPAIRED AND THEREBY PREVENT A SECONDARY GROWTH—CANCER.

ARKANSAS MEDICAL SOCIETY
RESOLVE TO START YOUR HEALTH YEAR RIGHT. DO NOT TAKE IRRESPONSIBLE ADVICE OR BE INFLUENCED BY HIGH PRESSURE RADIO SALES TALK.

ARKANSAS MEDICAL SOCIETY
AFTER EFFECT MAY BE WORSE THAN DISEASE. IF CONVALESCENCE DELAYED AFTER CHICKENPOX, MEASLES OR A COLD, FIND OUT WHY.

ARKANSAS MEDICAL SOCIETY
H. A. Rands, Dumas
†J. M. Kolb, Clarksville
W. T. Wootton, Chairman,
Hot Springs National Park,
Committee

REPORT OF COMMITTEE ON MEDICAL ECONOMICS

(Read by R. M. Blakely)

Your committee has made a study of the question of providing medical service to all groups. It is agreed that any program to be successful to meet the requirements should insure medical care, surgery and hospitalization to all groups.

To carry out such a plan it would be necessary to secure some source of finance. The principal sources studied were taxation, insurance company and mutual

group organizations. To finance such a service by taxation would require state and federal participation. The voluntary mutual insurance plan would require extensive organization and, in most instances, would result in an imposition on the plan by certain groups whose every increasing demands could not be met. The business method of insurance which would create a profit sharing business has the advantage of having an efficient business organization behind it.

Investigation reveals that in the United States, where the physician has the privilege of selecting his own location and the family has the privilege of selecting their own physician, the best medical service to the greatest number is rendered by the medical profession. This is an indorsement of our present system.

The tendency of the political influence today is toward compulsory insurance and regimented medicine. It is the opinion of your committee that we should not recommend any proposition that would give any advantage to those who favor state medicine. If such a plan were financed by taxation it would be government controlled. It is a known fact that he who holds the purse strings holds the governing hand. Laws concerning compulsory medicine in our opinion would be made on unreliable information. This is borne out by several medical reports made to Congress by certain public officials who favor compulsory plans. All physicians who have followed some of these reports know that they were made without sufficient facts and on distorted facts.

Your Economics Committee wishes to recommend that the Arkansas Medical Society indorse and encourage independent insurance companies in providing medical service protection for those who desire it. This position continues to endorse independent business. We also wish to recommend that the Arkansas Medical Society go on record against any plan for insurance or group medicine that would in any way jeopardize independent medicine.

H. E. Mobley, Chairman, Morrilton
 †J. H. Wilson, Wynne
 R. M. Blakely, Little Rock

REPORT OF COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS ANALYSIS OF PRIVATE HOSPITALS (42 Hospitals Reporting)

Questionnaires were sent to 81 hospitals over the state, and in four days response was obtained from 42, representing a total bed capacity of 1,663.

The hospitals reported an average bed capacity of 1,227. This shows that the hospitals have been 74% filled during the past year. However, in most of the centers where there is military activity such as Little Rock, Pine Bluff, Fort Smith, and Texarkana, the hospitals have been filled to capacity.

The 42 hospitals report on an increase of 50,214 hospital days over that of 1941. Our reports for 1941 showed an increase of 34,446 so that during the past two years, the increase in hospital days has been 84,650.

Seventy-five per cent of the hospitals reporting showed an increase in financial returns during the past year. Eighty-two per cent of the hospitals report that their institutions are on a satisfactory financial basis. Only 17 out of 42 hospitals reporting have been inspected by the American College of Surgeons. About seventy-eight per cent of the hospitals have an X-ray and clinical laboratory. Only fifty-five per cent of the hospitals have regular arrangements for tissue examination.

Forty-seven per cent of these hospitals report that Act 115 has worked to the advantage of their hospital. Twenty-six per cent of the hospitals reporting claim that their relations with Act 115 were unsatisfactory. Principal complaint of those reporting unfavorably is that the amount allowed (\$3.00) per day is not sufficient to cover cost at the present time.

Sixty-four per cent of the hospitals report that the personnel problem is a serious one and that they are unable to give the kind of service they would like to due to the shortage of technicians, nurses, etc.

Almost hundred per cent of the hospitals reported that they have a regular system of record keeping.

Seventy-one per cent of the hospitals reporting have been able to handle all patients applying for service. Thirty-six per cent report that they have waiting lists and are unable to take care of all patients applying for hospitalization.

The question was asked of the hospitals, "What do you think of postwar prospect for hospitals?" This question was answered in numerous ways. The majority said that they did not know what to expect. Some reported the outlook as doubtful. Others reported it as stormy. Very few have an optimistic view of the situation.

GROUP HOSPITALIZATION PLAN

Mr. J. M. Gunn has kindly submitted the following report:

Since our report to your Committee a year ago, many conditions and circumstances have arisen which have affected the Plan. Among these unusual circumstances might be mentioned:

1. The large number of men between the ages of eighteen and forty-five who have gone into the service, thus eliminating them as paying members of the Plan or as prospective members.
2. The larger than usual shifting from job to job occasioned by increased earning opportunities and the extraordinary demands for workers. This has made it difficult to service members moving from job to job and has retarded somewhat the enrollment of employees.
3. With keen competition for the services of men and women capable of becoming organizers, it has been more difficult, of course, to obtain satisfactory organizers. We have been fortunate on the other hand to hold together for the most part our force of splendid organizers.
4. More and more it becomes necessary to depend upon women as prospective new members and of course the number of employed women has increased greatly. It should be recalled, though, that women on the whole are much more costly to the Plan because they are hospitalized more often and for longer periods than are men. The preponderance of women covered by the Plan necessarily, therefore, tips the balance unfavorably, and constantly narrows the margin between total income and total expenditures for hospitalization.

In spite of these conditions which might be viewed after a fashion as handicaps, there are circumstances that are favorable for the progress of the Plan and we are happy to report an all-over growth of the Plan which we believe quite satisfactory in the light of conditions. The total income of the Plan increases from month to month. This is an excellent criterion by which to judge its sound progress.

It should be noted here that the success of the Plan is attributable to, and continues to hinge upon, the

conscientious cooperation of the members of the Medical Society in both the underwriting of risks on new members and in the hospitalization of members of the Plan.

In the two localities of Pulaski County and Jefferson County a most satisfactory progress has been made. The Plan has been able to hold its own, we believe, in the other counties. A picture of the Plan's activities may be had from the following facts:

1. Since the inauguration of the Plan 3,398 members and dependents have been hospitalized, with:
- A. An average stay of 7.20 days per patient.
- B. Of those hospitalized 2,271 (66.8% of the total) were female members and dependents, the total cost being \$79,686.89 (70.6% of the total cost).
- C. Of those hospitalized 1,127 (33.2% of the total) were male members and dependents, the total cost being \$33,149.79 (29.4% of the total cost).
2. Total savings to members aggregate \$112,836.67 in bills paid by the Plan, and total hospital days have amounted to 24,481.

Interesting from the standpoint of the ratio of medical, surgical, maternity and accident cases hospitalized, are the following figures:

Total hospital bills paid on medical cases	\$ 32,695.64
(28.98% of the total)	
Total hospital bills paid on surgical cases	62,502.88
(55.39% of the total)	
Total hospital bills paid on maternity cases	12,616.45
(11.18% of the total)	
Total hospital bills paid on accidents	5,021.70
(4.45% of the total)	
TOTAL	\$112,836.67

Maternity benefits play a more and more important role in hospitalization costs. For instance, in the calendar year 1941 maternity benefits amounted to only 4.2% of the total hospital claims, while in the calendar year of 1942, maternity benefits were 18.7% of all claims paid.

The average cost per person hospitalized in Pulaski County since the beginning of the Plan has been \$28.99 for males and \$35.60 for females.

It will be recalled that at the time of our report a year ago mention was made of a considerable deficit that had been incurred by the underwriters in the organization of the Plan. We are happy to report that by virtue of the splendid cooperation of the doctors and member hospitals, and through the best administrative practices of which we have been capable, the deficit has been materially reduced. Within a matter of months now, the entire deficit should be made up and the Plan then should be in position to:

1. Begin creating a reserve for epidemics and unforeseen contingencies.
2. Offer still further liberalization of benefits to members.

So far as our recollection serves us, there has not been a single complaint concerning the organization and administration of the Plan made by either members of the Medical Society or member hospitals. It has been and will continue to be our guiding aim to so conduct the Plan and its operations that there shall be no grounds for disappointment or criticism.

EDUCATION

During the past year practically no work has been done of a postgraduate nature in the state. It is not necessary to state the reason for this. We wish, however, to submit the report submitted by the Dean of Medical School, Dr. Byron L. Robinson. "Concerning the War Training Pro-

gram, we have no definite information from Washington as yet that might be considered official. We do know that we will be considered for it. In the light of the fact that we have secured permission from the Council of the American Medical Association to go on the accelerated program and the fact that the State Legislature has given us an increased appropriation, I do not believe there is any doubt but that we shall go on the program, possibly about July 1st."

ENROLLMENT

	1941-1942	1942-1943
Freshman Class	82	82
Sophomore Class	74	71
Junior Class	70	61
Senior Class	66	70
Total	292	284

GRADUATES

	June 9, 1942	June 8, 1943
Number holding commissions:		
Army	45	40
Navy	16	16
Public Health	2	2
Others	3	12
Total	66	70

All accepted interne appointments.

APPLICATIONS FOR FRESHMAN CLASS

	1941-1942	1942-1943	1943 (July 1)
Applications considered	222	405	129 (March 10)
Applications accepted	82	82	44 (March 10)

UNVIERSITY HOSPITAL

House Staff (July, 1941-July, 1942)	17
Internes	8
Assistant residents and residents	9
Average hospital bed occupancy for year 1942.....	164 or 78.1%

M. J. Kilbury reported for the Committee on Scientific Exhibit and invited members to visit the exhibit arranged by W. C. Langston of the University of Arkansas School of Medicine.

REPORT OF MATERNAL AND CHILD WELFARE COMMITTEE

President Robins handed this Committee the problem of Obstetric and Pediatric Care of the wives and children of non-commissioned men in our armed forces, to be financed by the Maternal and Child Health Bureau in Washington.

We met in Prescott last summer with Dr. Grayson, State Health Director, along with several past-presidents and hospital owners.

Plans were made for this work and presented to the Council. This body gave its approval and the entire set up was published in the Journal after having been accepted in Washington.

Numerous unpleasant incidents from different groups or sections started at once. None of these could be adjusted since Washington refused to alter the approved plan. A trip to St. Louis, by the State Secretary, Chairman of the Council and State Health Director for a

conference with a representative from the Maternal and Child Health Bureau, failed to get further concessions. Fortunately the funds were rapidly exhausted and the controversies stopped. Somehow Dr. Grayson was able to get \$22,000, which was \$12,000 more than anticipated. The issues involved in this matter have not been settled.

There has been no refresher work done the past year. No one accepted the offer of expenses to take graduate work in Obstetrics or Pediatrics. Several new Prenatal and Pediatric Clinics have been established by the State Health Department. The Health Department has continued the investigation of maternal deaths without material change in reasons for such. This work should be discontinued for the present due to shortage of office help.

We have only one recommendation, but it is considered highly important: More Prenatal and Pediatric Clinics should be set up in those areas where there is a shortage of physicians and in sections where midwives will be attending more and more mothers and babies.

S. A. Thompson, Chairman, Camden
Don Smith, Hope
R. D. Dickins, Monticello
†B. P. Briggs, Little Rock
†C. G. Leverett, Eudora
Robert Hood, Russellville
J. K. Walker, Pine Bluff
†Clyde D. Rodgers, Little Rock
E. C. McMullen, Pine Bluff
G. L. Kimball, DeQueen
R. C. Kennerly, Camden
C. R. Henry, Little Rock

SUPPLEMENTAL REPORT OF MATERNAL AND CHILD WELFARE COMMITTEE

Since committee reports were published in the April issue of the Journal, \$42,000 has been allocated to Arkansas for medical and hospital care of expectant wives and babies of men in our armed forces. The administration of this fund will be carried on by the State Health Director, Dr. W. B. Grayson. As usual, Dr. Grayson asked for the advice of our constitutional officers and this Committee.

A meeting was held in the State Health Building, Little Rock (if you have not seen this building you should take time out and go over it) April 6th, with the State President and Secretary, hospital representatives and this Committee.

Most of the changes in the operative plan of last year are minor. One change is very marked and important in that no group or class of doctors may be considered eligible as such.

There will be a technical advisory committee set up to confer with Dr. Grayson regarding physicians who wish to participate in this program. This committee will deal entirely with professional qualifications and whether he can qualify under the standards set by the Maternal and Child Health Bureau at Washington.

A study of bulletins at our April 6th meeting seemed to indicate a more liberal view on qualifications than that of last year and Dr. Grayson will be very much on the "Hot Spot" in this matter. He has always been very loyal to us in every respect and we should now return that loyalty and support in every way possible.

This \$42,000 will be all until July 1st after which there may be a regular monthly allotment.

Committee Maternal and Child Welfare
S. A. Thompson, M. D., Chairman

LIAISON WITH THE ARKANSAS TUBERCULOSIS ASSOCIATION

We have kept in close touch with the work of the Arkansas Tuberculosis Association which has, during the past year, adhered closely to the functions as laid down by the National Tuberculosis Association, viz:

An educational program including case finding surveys, skin testing in the schools, X-raying positive reactors, and, from these endeavoring to locate the open cases.

The early diagnosis campaign in which clinics are held in conjunction with the State Public Health Department at the invitation of county medical societies.

A study and adoption of a program for the coming year along these lines plus educational work in the public schools.

In this type of program we have had the hearty cooperation of the medical societies, the public schools and the State Health Department.

The legislative provision for skin testing and X-raying the positive reactors among teachers, food handlers, bus drivers, and all the personnel of the schools, was introduced during the meeting of this Legislature but up to the time of this report had failed to pass because of the crowded calendar. It is the sense of this Committee that there will be no trouble passing this bill as there was no objection raised anywhere except that the Committee of Education thought it might work a hardship on some of those affected.

The Committee recommends that the Arkansas Medical Society continue to endorse the enactment of this law and that each member speak to his representative and senator before the next Legislature concerning its need for the control of tuberculosis.

A. C. Shipp, M. D., Chairman

REPORT OF THE COMMITTEE ON POSTGRADUATE STUDY

This will serve as a report from the Chairman of the Committee on Postgraduate Instruction of the Arkansas Medical Society.

At the beginning of the last year, it was very difficult to decide whether or not the activities of the Committee should continue as they had in the past. There were many factors in the outlook which did not indicate a successful postgraduate course could be held. Among these, the outstanding ones were tire and gasoline rationing and the scarcity of doctors all over the state. It seemed unlikely that the meetings would be well attended.

After due consideration, the Committee on Postgraduate Instruction decided to postpone further activities until the outlook had become more favorable.

Very truly yours,

D. A. Rhinehart, M. D., Chairman,
Committee on Postgraduate Instruction, Arkansas Medical Society

COMMITTEE ON INDUSTRIAL HEALTH

During the past year, your Committee has endeavored to continue the study of the needs of the physicians in the state for more information concerning the care of the industrial worker along the lines of industrial accidents and industrial health.

Industrial health, as well as industrial medicine and surgery, has become more important than ever before because of the increased production effort that industry

is putting forth because of the war conditions. To prevent disease and heal the ill has always been the aim of the medical profession both in war and peace. The medical profession has never digressed from that ideal.

We are called upon now to apply our knowledge of public health and hygiene and care of the sick to new or expanded industries and their working personnel. The medical profession, as a whole, in regard to industrial health, is considerably late. There are a few men who saw the light and followed it but the vast majority of physicians in general practice have not appreciated the light shed upon industrial health. Now, it has fallen upon our shoulders. The majority of our great profession, in humility, are called upon to ask those leaders in industrial health to instruct their colleagues in important techniques which years of pioneering in industrial health and hygiene have developed.

Our goal can be very simply stated. We want a well worker on every job in this state and we want to safeguard him so that his working environment can not strike at his life or health. A simple statement but it embraces a large subject and implies a most appalling amount of work. It means that our professional worker in industry is really the entire field of public health and hygiene applied to the working place.

When a practicing industrial physician utters the words, "Industrial health," he is talking of the vast field that is to become paramount in the coming generation. He is not talking about accidents after they have occurred, nor the injured worker. He may have graduated from that many years ago. He is talking about a medical endeavor that includes the medical and surgical profession and all of its specialties.

Last December, your Committee met at the Albert Pike Hotel with Dr. Orlen J. Johnson, Council on Industrial Health of the American Medical Association, and discussed at length the various problems of industrial health and ways and means by which they might be solved.

Dr. Johnson made several suggestions that might be followed in this state.

1. That industrial health be included in a program of the State Medical Meeting.
2. That those county societies in our state that have industry should devote one or more meetings a year to industrial health. He suggested that the state society set up a speaker's bureau to provide programs for county societies, stating that this had been carried out successfully in some states.
3. That institutes or conventions be held in such cities as need this treatment; suggesting that this might be done in Fort Smith and Little Rock.

Our report last year, set up a definite program which was adopted by the Reference Committee. The State Board of Health agreed to make an effort to carry out the greater part of this program. What has been done, I am unable to say. But, I think Dr. Hearn of the State Board of Health has made considerable effort to carry out that program.

I have asked that county committees on industrial health be appointed in some eight counties. In response to that suggestion, I received four replies. Your Committee feels that in each county where there is industry sufficient to justify that county committees should be appointed to work with the state committee.

Maintenance of health in industry is a collective responsibility. Worker and employer, plant physician and family doctor all have a part to play, and each one's manner of playing may affect the others. Now that our very existence as a free nation depends on the output of

war industry, and that in turn upon continuity and efficiency at the job, we must each accept our part in our collective responsibility. There has never been a greater opportunity for the highest type of medical services.

E. E. Barlow, Chairman, Dermott

S. J. Albright, Searcy

Fred W. Harris, Little Rock

†J. Donald Hayes, Little Rock

M. E. Foster, Fort Smith

S. A. Drennen, Stuttgart

COMMITTEE ON MENTAL HYGIENE

We, the Committee on Mental Hygiene, report the accomplishments of the past year and make recommendations for further steps in behalf of the mental hygiene program in our state.

ACCOMPLISHMENTS

First. We report with tremendous satisfaction the revision of our admission laws to the State Hospital. We can now legally take in voluntary admissions.

We can now admit patients upon the recommendation of any doctor in the state without commitment papers.

Henceforth, the only patients committed to the State Hospital will be those whose condition is such as to convince the State Hospital staff that a commitment is necessary: That is, for those who might hurt themselves or others if outside and who refuse to stay voluntarily. These commitments will be made upon the recommendation of the hospital staff to the chancery judge of the district from which the patient came. As can be seen, this places the mental patient on the same basis as other sick people: No court, no trial with all its embarrassment to the family and, we hope, no sheriff. By no sheriff, we hope that you doctors are going to bring the patients to the hospital. Taking the mental patient away from the courts will be a most important step in removing the stigma associated with mental disease and the State Hospital.

Second. We feel that the nice increase in appropriation for the State Hospital for the coming biennium is indicative of a better understanding of the problems and needs of our mental patients.

Third. Constitutional Amendment No. 33 stabilizes the State Hospital Board for the future. This provides for a staggered board, the membership of which can never be changed in its entirety during any one administration.

Fourth. Although our national emergency has delayed the establishment of the Psychiatric Unit at the Medical School, the opening wedge has been placed and a definite recognition of its need has been well established in the minds of the people and the medical profession.

RECOMMENDATIONS

First. We wish to emphasize the fact that although the State Hospital has had a tremendous boost in making of it what it should be, it can never be of maximum service to our state until every doctor in the state is:

(a) Mental disease conscious.

(b) Is sold on early diagnosis and treatment of mental diseases.

(c) Knows our State Hospital, what it can do, as well as what it cannot do.

(d) Refuses to cooperate in dumping upon the State Hospital just destitute and physically ill patients.

Second. All the foregoing has to do with the treatment of mental diseases. We hope that with the insti-

tuting of a mental hygiene program in our State Health Department we can begin to get the benefit of preventive medicine in this field.

N. T. Hollis, M. D., Chairman
George B. Fletcher, M. D.
A. C. Kolb, M. D.
Elizabeth Fletcher, M. D.
Pat Murphey, M. D.

RESOLUTION BY THE MENTAL HYGIENE COMMITTEE

WHEREAS, the 1943 session of the State Legislature passed some legislation which will mean much to the State Hospital in the care and treatment of the mentally sick of this state, namely: (1) the new admission law; (2) an increased annual appropriation from \$912,500 to \$1,280,550. This increase provides for increased salaries of attendants, supervisors, nurses, and medical staff. All this means better personal services to the patients. (3) \$200,000 was appropriated for new buildings at the Benton Unit. This will do much to relieve the present overcrowded conditions of the institution, and

WHEREAS, the question of the abandonment of the Little Rock Unit of the State Hospital and locating the entire institution at Benton was debated in the Senate during the recent session of the Legislature and a resolution was passed by that body re-affirming a former resolution passed by the Legislature in 1928 providing for the abandonment of the Little Rock Unit of the State Hospital and the location of the entire institution at Benton, and

WHEREAS, the State Hospital is an institution for the diagnosis, care and treatment of the mentally ill from every section of the state and is, therefore, a medical problem best understood by the medical profession of the state, and

WHEREAS, Little Rock is the geographical center of the state and much more accessible to all the people in visiting their loved ones who are patients in the State Hospital, than Benton. The acute mentally ill are visited more frequently than the chronic cases, and

WHEREAS, consultation service with the specialists of the Little Rock medical profession should be maintained at all times for the benefit of the patients in the institution. A modern unit for the treatment and care of the tuberculous patients of the State Hospital should be provided at the Little Rock Unit, also a modern unit for the care and isolation of the criminal insane should be constructed at the same place. The Little Rock Unit should be maintained as a teaching asset to the School of Medicine of the University of Arkansas. Even though a psychopathic unit should be built later at the medical school, it would be necessary to exchange patients frequently between these units. The tuberculous patients could be utilized for teaching purposes by the medical school. All the above would be impossible with the entire institution located at Benton.

THEREFORE, BE IT RESOLVED, that the Arkansas Medical Society by action of the House of Delegates places itself on record as opposing the abandonment of the Little Rock Unit of the State Hospital for reasons listed above, and further goes on record that the said Arkansas Medical Society, through its governing body, the Council, should be consulted as to any future policy affecting the State Hospital such as the location of units, size of units, and any other medical problem affecting the institution in its work of caring for the mentally sick of the state.

BE IT FURTHER RESOLVED, that an Advisory Committee composed of the President, Secretary, Chairman of the Council, and two ex-Presidents be appointed as a permanent body to represent the Arkansas Medical Society as a consulting committee to work with the Governor or other legal constituted authorities in all medical matters in connection with our state institutions, the medical school, medical welfare problems, including Act 115, and the establishment of a future state-wide mental hygiene program.

ALSO BE IT FURTHER RESOLVED, that this resolution, if passed, be given publicity through the press.

REPORT OF THE SECRETARY OF THE STATE MEDICAL BOARD OF THE ARKANSAS MEDICAL SOCIETY FOR 1942-1943

Since the last meeting of this body in 1942, the State Board of Medical Examiners has held two regular sessions and two call meetings.

The Desha County Medical Society, with the financial help of the Board has successfully prosecuted one man for violation of the Medical Practice Acts of this state. The Board has revoked the licenses of four physicians for violation of the Harrison Narcotic Law. We have restored the license of one physician who had served time in the Federal Correctional Institution for violating the same law. We have asked the Narcotic Bureau to withhold the narcotic license of two physicians who had used narcotics indiscriminately. Also, we have asked the Bureau to restore to two physicians their narcotic license who had been guilty of the promiscuous use of narcotics in the past.

At the June meeting 43 students from the University took examinations in their primary subjects. At the June meeting 22 who were graduated from the University of Arkansas took their final examination and 38 doctors, the full or complete examination. At the November meeting, there were 25 students who took the primary examination and one doctor who took the complete examination.

During the past year, one duplicate license was issued due to the destruction of a license. Since the last meeting of this body, 27 physicians have been certified to other states and 11 physicians have come to this state by reciprocity.

The Secretary of this Board attended the meeting of the Federation State Secretaries and the Congress on Medical Education in Chicago this February. The usual question of the licensing of refugee physicians was discussed along with the question of the physicians entering the armed forces of this country, and the relocation of physicians from one state to another. Also, a plan was presented by which physicians could be transferred from one state to another during this emergency without having to secure license in any state to which he might be sent. Also, refugee physicians might be sent to any location in which they might be needed. It was found out many states had specific laws governing the location of refugee physicians and also the relocation of other physicians. Many states will have to change these laws by legislative acts.

Some states have gone so far as to change some of their medical legislative acts to confirm to the suggestion of the Congress on Medical Education, but your Board, after a special meeting and thorough discussion of this question, decided at the present time it was unwise to jeopardize our present medical acts by any

new medical legislation, and further agreed, that any physician who wanted to be relocated in this state would have to go through the same process as any man securing license in the past, because most men who are seeking relocation are from inferior schools or schools that our Board does not recognize at the present time.

Our Board has in no way lessened the standards of medical licensure in this state during the emergency and we hope we will not have to do so. So far as we know, there are very few instances where the public is not receiving adequate medical care.

Howard C. Elliott, Washington, D. C., who is in the training division of War Manpower Commission, made an important statement; that just as soon as the war was over, all physicians would not return to civilian practice. A great number of the physicians who are now serving in the armed forces would probably be kept by the Army to help care for the soldiers who would be maintained or kept in foreign countries for police duty or in the role of rehabilitation, because a large number of foreign physicians will be injured the same as soldiers of the same country, and a large part of this work, of medical service, will be forced on American physicians.

It was suggested that the House of Delegates of this body, be instructed to have the delegates from the Arkansas Medical Society, along with delegates from other state societies, request the American Medical Association at their next meeting to establish and maintain a Bureau of Medical Information in Washington, D. C. This Bureau should be maintained so that our Senators and Representatives could secure any information or data they desire on medicine or anything pertaining to the practice of medicine in these United States.

A great deal of discussion took place with regard to a universal reciprocity. As it is, at the present time, some states do not reciprocate with any other state. Most states do have reciprocal agreements. Arkansas reciprocates with 43 states and the territory of Alaska. It will take a good deal of legislation and changing of state laws to secure a universal reciprocity. Many states are having trouble with reciprocity because they have no basic science board. Of course, if universal reciprocity is ever worked out between the states, a certain uniformity of medical schools will have to be taken into consideration.

At the present time, many states under the present state laws, are required to examine any physician for license who may present to them a degree of medicine. He is not barred by nationality, country, or class of school, and as you all know, in our state, we only examine men from class "A" medical schools who are American citizens. In order to work this out, the standards of many states will be raised and the standards of a few states lowered.

The universal licensure seems to be one of the big problems at the present time to face this country, especially with the present status of national affairs and with the return of our physicians from the armed forces seeking new locations and the return of those doctors who have never engaged in general practice or any practice at all and will have to find and establish for themselves a practice when they do return home.

It is estimated by the army and navy physicians who attended this meeting, that about 50% of the medical men of this country will be in the armed forces by the end of year 1943; especially, if the armed forces are raised to the total which is being looked forward to, approximately ten and one-half million men.

The Official Directory is in the hands of the printers and will be off the press in a very short while. The cause

of the slight delay was that so many physicians felt as if there would be no collection of the registration fee during the present emergency, and it has taken a tremendous amount of correspondence and time to keep all the men notified that the Board was unable to withhold an annual collection to the men in civil practice. The Directory was also delayed because we wanted to try and get the names of each physician in the armed forces in the Directory and there may be a few whose names we have not succeeded in getting but we have put forth every effort to secure these names. The registration fee of the men serving in the armed forces have been waived for 1943, and each successive year, so long as the emergency exists.

For the year 1942, there was a total of 1,345 physicians registered that we were able to locate. 1,308 of these physicians paid their 1942 registration fee and 37 were delinquent. For the year 1943, 1,036 had paid their registration fee; 245 in the armed forces, and six physicians died; or a total of 1,327 who ordinarily would have paid. This leaves 18 who have not paid and are unaccounted for. Part of these may be in the armed forces and this office has no record of their whereabouts.

During the coming year the terms of the following members of the State Medical Board of the Arkansas Medical Society will expire and the Society should, at this time, make nominations for submittal to the Governor: First Congressional District, Robert Haley, Paragould; Fourth Congressional District, L. J. Kosminsky, Texarkana, and Fifth Congressional District, Robert Hood, Russellville. Each of these members has served but one term and is eligible to reappointment.

A RESOLUTION

To be presented to the House of Delegates of the American Medical Association at its next annual meeting in Chicago in June for establishing a Committee on Medical Service.

WHEREAS, the medical profession is conscious of its responsibilities in providing timely and adequate medical services to all of the American people, irrespective of race, creed or financial status, and

WHEREAS, it believes it to be its duty and right to make available scientific facts, data and medical opinion with respect thereto, and to make known the role that the science and art of medicine plays in the daily lives of all Americans, and

WHEREAS, the medical profession of the United States is ready to offer constructive leadership in the advancement of medical principles that will further medical service to all of the people, and to preserve, not only the science and art of medicine, but the standards associated with the practice of medicine in America;

NOW, THEREFORE, BE IT RESOLVED, that there is hereby created by this House of Delegates a Committee on Medical Service which shall be composed of the following members:

1. The president of the American Medical Association, ex-officio.
2. The Immediate Past-President of the American Medical Association.
3. The Secretary of the American Medical Association, ex-officio.
4. A member of the Board of Trustees of the American Medical Association, designated and selected by the Board of Trustees.
5. One member of the American Medical Association elected as hereinafter provided from each of the

following nine geographical subdivisions of the United States:

New England—Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut.

Middle Atlantic—New York, Pennsylvania, New Jersey.

East North Central—Ohio, Indiana, Illinois, Michigan, Wisconsin.

South Atlantic—Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida, Puerto Rico.

East South Central—Kentucky, Tennessee, Alabama, Mississippi.

West South Central—Arkansas, Louisiana, Oklahoma, Texas, Panama Canal Zone.

West North Central—Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas.

Mountain—Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada.

Pacific—Washington, Oregon, California, Alaska, Hawaii, Philippines and Pacific Islands.

The members of this House of Delegates from each of the foregoing geographical subdivisions of the United States shall elect one member of the American Medical Association to serve on said Committee; three of said nine members shall serve for one year; three shall serve for two years; and three shall serve for three years; the respective terms of office of the nine members first elected shall be decided by lot and thereafter the said terms shall be for three years each. The expiration date for the first one year term shall be at the next ensuing annual session, of the House of Delegates of the American Medical Association. Expiration dates for all terms shall coincide with the dates of the regular annual session, of the House of Delegates of the American Medical Association.

BE IT FURTHER RESOLVED, that the duties of the Committee on Medical Service shall be:

1. The making available of scientific facts and data and medical opinion with respect to timely and adequate rendition of medical care to the American people.

2. To integrate the activities of the Committee on Medical Service with respective state and county committees on like activities.

3. Establish relationships and cooperation with other allied groups who are likewise engaged in the rendition of medical care, in its various branches, to the American people.

4. The Committee on Medical Service shall hold at least two meetings per year; one shall be held at the time and place of the Annual Meeting of this House of Delegates; the other meeting shall be held in the City of Washington, D. C., and called at the direction of the Chairman; and such other meetings as may be necessary to be called by the Chairman upon the written request of the majority of the Committee.

5. The Committee shall forthwith and annually thereafter elect from its own membership a Chairman and a Vice-Chairman.

6. The Committee on Medical Service shall establish and maintain an office in Washington, D. C., and shall further be empowered and directed to employ a full-time Executive Director, who shall act as Secretary of the Committee, and, whose duties shall be specified by the Committee. Such Executive Director shall be a physician who has been actively engaged in the private practice of medicine for not less than five years during the previous ten years, and furthermore, be informed and qualified to act as a Liaison Representative of said Committee.

7. The Committee on Medical Service is further authorized to hire such legal and administrative help as is necessary.

BE IT FURTHER RESOLVED, that the Committee on Medical Service shall submit a Budget for its expenses for the fiscal year to the Board of Trustees of the American Medical Association and it is the consensus of opinion of this House of Delegates that the Board of Trustees shall forthwith appropriate not less than fifty cents nor more than one dollar for each member of the American Medical Association so that adequate funds will be available for such Committee to carry out its work on an honorable and ethical plane in keeping with the standards of American Medicine.

BE IT FURTHER RESOLVED, that this Committee shall submit an Annual Report to the House of Delegates at their Annual Meeting.

AND BE IT FURTHER RESOLVED, that this resolution upon its adoption by the House of Delegates shall be forthwith transmitted to the Board of Trustees with the request that the Board of Trustees report back its action to the House of Delegates within twenty-four hours as provided for in the Constitution and By-Laws of the American Medical Association.

REPORT OF COMMITTEE ON CANCER CONTROL

The activities of the Committee have been greatly hampered due to the war and gas rationing. Considering the difficulty with which we are faced we feel that while no great amount of constructive work was done, that which was done was of a constructive nature and has been very encouraging to the Committee.

The first meeting was held in Little Rock at which time Mrs. W. R. Brooksher met with us and a conference was held on the problems of the Women's Field Army. Necessary expenditures of the Women's Field Army were approved and we commended the constructive work which is being done under Mrs. Brooksher.

The first training school for officers and co-workers of the Arkansas division of the Women's Field Army was held in February. The school had forty-six attending. Different phases of the cancer problem were discussed by Dr. Shields Abernathy of Memphis and by your chairman.

Following the morning session of the school a cancer clinic was held at the St. Bernard's Hospital by the physicians of Jonesboro, assisted by Drs. Abernathy and Hames. One hundred and twelve patients presented themselves for examination. Approximately forty per cent of those attending the clinic were found to have had cancer in some form.

Your Committee is of the opinion that these schools should be continued and that when things are normal again, cancer clinics should be held in those areas desiring them where local cooperation can be obtained.

The work of the Women's Field Army has been greatly hampered due to the war. Your Committee, however, felt that the work should not be dropped and that we carry on as best we could. Your chairman is particularly appreciative of the cooperation of the other members of the Cancer Committee. They have responded most admirably considering the handicaps over which we had no control.

Respectfully submitted,

Fred Hames, Chairman, Pine Bluff

†Fred H. Krock, Fort Smith

†Vincent O. Lesh, Fayetteville

Glenn Johnson, Little Rock

D. E. White, El Dorado

REPORT OF COMMITTEE ON SYPHILIS

HEALTH DISTRICT NUMBER ONE

203 24th Street, Ogden, Utah

February 18, 1943

Dr. W. R. Brooksher, Secretary
Arkansas Medical Society
Fort Smith, Arkansas

Dear Bill:

I have your letter of February 3 concerning the report of the Committee for the Control of Syphilis. This letter finally reached me here in Utah.

Last September I was ordered by the U. S. Public Health Service to report to Denver, Colorado. We packed our furniture hurriedly, loaded it on a moving van and started for Denver on September 10, reporting to District 8, headquarters in Denver. I remained there about ten days getting orientated in the procedures of the U. S. Public Health Service. From there I was sent to the Utah State Health Department in Salt Lake City and worked from out of that office in the central part of Utah for about a month. Upon the resignation of the director of District No. 1, which comprises seven counties in the northern part of the state, I have been acting as director of District No. 1 with headquarters in Ogden. The U. S. Public Health Service has loaned two health officers to Utah because of the fact that there is considerable construction of ordnance supply deposits in this area. There are also a number of air bases and army camps. We even have a navy supply depot on the banks of the great Salt Lake which is now near completion.

I have been rather busy taking blood Wassermanns and giving typhoid shots and smallpox vaccinations to civilian workers. Found about 415 cases of syphilis at the Naval Supply Depot which I have been endeavoring to keep under treatment. Also the fact that I am supposed to be responsible for the health of one-fourth of the population of the State of Utah keeps me rather busy.

I regret very much that I will not be able to attend the meeting of the Arkansas Medical Society this coming spring. For several months past I have been reviewing the laws of various states that have been passed to help in the control of syphilis and have come to the conclusion that one of the best things that our Committee could do would be to sponsor laws requiring premarital blood Wassermanns and Wassermanns on all antepartum cases. Utah has passed such laws and they are working out very nicely at the present time. I am mailing a copy of these laws to Dr. R. B. Robins and have requested that he forward these on to the other members of the Committee. I sincerely believe that this would do much to find and eradicate syphilis in our population there in Arkansas. In fact I feel so strongly concerning this matter that it seems to me that it would be well to have a national law controlling this so that no couple could go across the state line and secure a marriage certificate without having a recent Wassermann. Let's get busy and see that these laws are passed at an early date so that Arkansas will not be one of the "tail-end" states to pass a good measure as we have most always been in the past. These laws have been tried long enough to prove their value. Therefore, it behooves us to get busy and do something about it immediately.

My home address is 111 "I" Street, Salt Lake City, Utah. I am still receiving the Arkansas Medical Journal

and read with much interest your "patter" and what the doctors there in the service are doing.

Very truly yours,

Wm. P. Scarlett, M. D.,
Surgeon (R),
U. S. Public Health Service,
Director of District No. 1,
Utah State Department of Health

E. E. Barlow called attention to the report of the Delegates to the American Medical Association as published in the September, 1942, issue of The Journal.

By motion (Barlow-Rush) the report was accepted.

REPORT OF TREASURER

ARKANSAS MEDICAL SOCIETY

April 18, 1942-April 6, 1943

Balance, April 18, 1942:

Pulaski Federal Savings & Loan	\$ 5,000.00
Commonwealth Federal Savings & Loan	2,500.00
Savings Account	986.71
Checking Account	8,851.22
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	\$17,337.93

Receipts:

From Secretary	10,000.00
Dividends—Pulaski Federal Savings & Loan Association	150.00
Commonwealth Federal Savings & Loan Association	75.00
Purchase—War Bonds, Series G	900.00
Dividends—War Bonds	11.25
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	\$11,136.25
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	\$28,474.18

Disbursements:

Vouchers 1319-1404 inclusive	\$12,827.35
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Balance—April 6, 1943:

Pulaski Federal Savings & Loan	\$5,000.00
Commonwealth Federal Savings & Loan	2,500.00
War Bonds, Series G	900.00
Checking Account	7,246.83
	<hr/>

\$15,646.83

Respectfully submitted,

PAUL L. MAHONEY, M. D., Treasurer

REPORT OF THE SECRETARY

The membership of the Society today is 960. At the request of the Council, Benton, Crawford, Hempstead, Independence, Jefferson, Johnson, Lincoln, Mississippi, Ouachita, Phillips, Pulaski, Sebastian, and Washington county medical societies paid the assessments of 120 of their members who are now in the military service. For 67 other members, the State Society waived the assessment.

The various activities of the Society have continued through the past year, restricted, in some degree, because of the loss in members and because of the additional patient load upon those who remain. County medical societies must continue to meet regularly during the war

† In Military Service.

in order that there be no loss in the strength and force of organized medicine and in order that there may be full dissemination of scientific knowledge. Federal authority has recognized the need for a continuation of local, district and state medical society meetings and all are urged not to forego these meetings despite obvious difficulties.

Despite budgetary restrictions and wartime limitations, The Journal has endeavored to progress. For the coming year there will be a shortage of scientific material due to a shortening of the annual session and county societies are urged to submit for publication meritorious papers presented to them. Increasing difficulty is encountered in keeping current the mailing list of our members who are in service and it is hoped that all who know of changes in their addresses will promptly notify The Journal.

For over a year your Secretary has acted as State Chairman for the Procurement and Assignment Service, the agency set up by organized medicine to meet the wartime need for physicians in the armed forces. The 1942 quota assigned Arkansas was filled prior to September 1st and, for the present, no physicians are to be called from Arkansas. It is emphasized, however, that urgent need still exists in the armed forces for physicians under the age of 38, and those who remain in the state and who may be spared from their communities should volunteer for immediate service. Your chairman is most appreciative of the whole-hearted cooperation he has received from the county chairmen in the work of the Procurement and Assignment Service. To those who volunteered in answer to the call for physicians, our thanks cannot approach the satisfaction which must be theirs in the knowledge that they are so well serving our country.

During the summer, the state president, the council chairman, the chairmen of the Committee on Medical Legislation and the Secretary addressed special meetings in seven councilor districts on various matters of interest to the profession. The impression is obtained that this was a desirable innovation and that it should be continued to bring forcibly to the attention of the membership matters of important policy.

The medical profession stands in need of great courage at this time. Yearning for power, ignorance, greed and selfishness are too rampant on the part of man. If medicine and the health of the people are to remain at the highest ideal and to well serve this country, friendship and intelligent, honest cooperation must be established between the people, the statesmen, management, labor and the professions. A failure to do so will result in the exploitation of state and contract medicine by political racketeers or selfish private interests. It is the province of medicine, as a part of society, to supply unselfish leadership and adequate social adaptability. Medicine should take stock, re-evaluate its past activities, its successes and its failures. Medicine must convince the public of its ability to adequately assume the responsibility for education along matters of public and private health. The field of education by medicine ranges from the sick-bed to the home, the school and our assemblies.

The future of medicine will remain bright only if those in medicine keep constantly alert; if they are willing to fight vigorously for the right, but, at the same time, show a readiness to alter their attitude when shown conclusively and scientifically that it is wrong.

For the kind help and consideration of officers, committeemen and members in the performance of our duties during the year, we express grateful appreciation.

The House then proceeded to select the following Nominating Committee: 1st District, J. H. McCurry; 2nd District, G. C. Burton; 3rd District, J. O. Rush; 4th District, E. E. Barlow; 5th District, J. H. Wilson; 6th District, A. S. Buchanan; 7th District, H. L. Brown; 8th District, S. C. Fulmer; 9th District, J. G. Gladden, and 10th District, S. J. Wolferman.

The following telegram was read to the House:
WISH WE COULD BE THERE WITH YOU
TODAY. THIS IS THE FIRST WE HAVE MISSED
IN THIRTEEN YEARS.

MADGE AND EUCLID SMITH.

The House of Delegates then adjourned at 12:10 P. M.

SCIENTIFIC SESSION

Monday Afternoon, April 19th, 1943

The meeting was called to order by President Robins at 1:45 P. M.

The invocation was given by the Rt. Rev. Msgr. John J. Healy, Director of Catholic Hospitals, Little Rock.

Alan G. Cazort, President, Pulaski County Medical Society welcomed the Society to Little Rock.

"In behalf of the Pulaski County Medical Society, I bid you welcome, a welcome warmer this year than usual. We know you have come at a sacrifice to your various communities. We sincerely hope the good derived from this meeting will more than balance this sacrifice.

"Although war conditions preclude the customary entertainment, we trust the professional fellowship will be heightened. The facilities of the medical school and the various hospitals are at your disposal.

"Our joy in greeting you is considerably affected by the absence of many faces, loved and respected by all of us. Those of us here are carrying a double load, but those in the service face immediate discomfort and danger and future insecurity.

"There is no doubt that we, on the home front, will discharge our professional responsibilities adequately. We have an even deeper obligation to our absent colleagues, an obligation of the soul, that is immediate, but also extends into a difficult period of reconstruction.

"Let us make a pact with these colleagues of ours. While they help us with guns, let us help

them, through the Red Cross, and by investing our investible earnings in War Bonds. When they return, let us welcome them with all the help possible to their well-earned place in whatever economic system shall prevail."

Vice-President S. A. Drennen responded to the address of welcome.

Vice-President Drennen took the chair.

President Robins read the annual President's Address (page 1).

President Robins introduced W. T. Wootton, President-Elect, Southern Medical Association.

"At this time it is my privilege and great pleasure to recognize one of Arkansas' favorite sons in medicine. He is a man respected and loved by the profession in Hot Springs, a man respected and loved for many years by the membership of the Arkansas Medical Society, and a man respected and loved by the physicians of the South, as is evidenced by the fact that so recently he was chosen as President-Elect of the Southern Medical Association, which, in my opinion, is the second highest honor that can be conferred upon a doctor in this country.

"In recognition of this high honor and as a token of our esteem for you Dr. Wootton I would like to present this gift to you from the Arkansas Medical Society."

President Robins then presented Dr. Wootton with a silver tray inscribed to commemorate Dr. Wootton's service as President, Arkansas Medical Society, and as President-Elect, Southern Medical Association.

Dr. Wootton responded to the presentation.

"The element of surprise renders me practically speechless. This visible evidence of your friendship and goodwill towards me, this beautiful silver plate engraved with the date of two memorable occasions in my medical career, shall go down as a family heritage and merit the pride with which it shall be exhibited.

"It is indeed a signal honor that the Southern Medical Association has bestowed upon the Arkansas Medical Society in asking that one of our members serve as head of that organization next year. It was not a matter of routine that Arkansas was chosen for the honor at this time. Many years ago our own Dr. W. R. Bathurst became our councilor to the Southern Medical Association. He made such an enviable reputation and so endeared himself to the men with whom he worked, that he was selected to be the first president from the Arkansas Medical Society, and the only one up to this time.

"It has been my privilege to know rather well all of the men who have served as councilors

from Arkansas to the Southern Medical Association, and I think I can truthfully say that I have never known one who was held in greater respect, one who has accomplished as much with complete absence of friction, or one who has made wider or deeper friendships for himself and, therefore, for the whole organization he represents, than has our own Sid Wolferman.

"Fellow members of the Arkansas Medical Society, I have no illusions as to my standing in contemporary medicine. During the forty years I have practiced medicine beside you, it has constantly been my aim and effort to raise myself to the stature of the average Arkansas doctor, and if I have done this it is glory enough.

"Once more I heartily thank you for your evidence of friendship."

The scientific program then followed in order.

"Surgery of the Gallbladder and Common Duct," R. L. Sanders, Memphis.

"New Concepts in the Diagnosis and Treatment of Poliomyelitis" (Lantern slides and motion pictures), F. Walter Carruthers, Little Rock.

"Industrial Dermatoses," D. W. Goldstein, Fort Smith.

"Analysis of Thyroid Surgery" (Little Rock Hospitals), J. Harry Hayes, Little Rock.

The Pulaski County Medical Society was host for a buffet dinner at 6:00 P. M. in the Marion Hotel.

PUBLIC MEETING

MARION HOTEL

Monday Evening, April 19th, 1943

The meeting was called to order by Alan G. Cazort, President, Pulaski County Medical Society.

The invocation was given by Dr. Marion A. Boggs, Second Presbyterian Church.

President R. B. Robins was then introduced and presided.

Mrs. Richard Clark, President, Woman's Auxiliary to the Southern Medical Association, Hattiesburg, Mississippi, addressed the meeting on "The Medical Auxiliary in Wartime."

Dr. John H. Musser, New Orleans, addressed the meeting on "The War and Medical Education."

Dr. Marion A. Boggs gave the benediction.

SECOND GENERAL SESSION

Tuesday Morning, April 20th, 1943

The meeting was called to order at 9:45 A. M. by President Robins.

The scientific program was then presented in

order:

"Care of the Insane in the State of Arkansas" (with motion pictures), Geo. B. Fletcher, Hot Springs National Park.

"Leukemia and Aleukemic Diseases," M. J. Kilbury, Little Rock.

"The Doctor's Heart," John H. Musser, New Orleans.

"A Safe and Sane Method of Treatment in Neurosyphilis," L. G. Martin, Hot Springs National Park.

MEMORIAL SESSION

April 20, 1943

The meeting was called to order by President Robins at 11:30 A. M.

The invocation was given by Rev. Fred R. Harrison, Pulaski Heights Methodist Church.

A musical selection was given by the sextette—Mrs. Lawrence Witherspoon, Mrs. William F. Clements, Mrs. I. B. Richardson, Mrs. H. D. Mayer, Mrs. H. E. Riley and Mrs. W. R. Richardson, Mrs. Conrad Farrell, accompanist.

Mrs. E. D. McKnight, Brinkley, read the names of the deceased members of the Auxiliary.

O. J. T. Johnston, Batesville, gave the Memorial Address and read the names of the deceased members.

IN MEMORIAM

Orlando Conrad Hankinson, Pine Bluff, April 14, 1942
James William John, Pine Bluff, May 2, 1942
Orlie Parker, Wabash, May 11, 1942
Frank A. Gray, Batesville, May 18, 1942
James Louis Post, Van Buren, May 24, 1942
Dred D. Dorente, Fort Smith, June 17, 1942
Frank Prior Hardy, Searcy, June 22, 1942
Rufus W. Ratliff, Jonesboro, June 23, 1942
Joseph Stephen Westerfield, Conway, June 28, 1942
Leon E. King, Hot Springs, July 10, 1942
John Henry Weaver, Hope, July 15, 1942
Benjamin Comer Routon, Ashdown, July 19, 1942
Jeff T. Holcombe, Mineral Springs, August 5, 1942
Clyde Vernon Powell, Forrest City, August 13, 1942.
John M. Stewart, Van Buren, August 17, 1942
Frank Vinsonhaler, Little Rock, September 1, 1942
John W. Ringgold, Ashdown, September 8, 1942
Robert Joseph Haley, Sr., Paragould, September 14, 1942
Harry Thomas Harr, Fayetteville, September 16, 1942
James Monroe Matthews, Morrilton, September 25, 1942
Otto Ralph Honomichl, Hackett, October 3, 1942
Estes Allen, Little Rock, October 17, 1942
Charles A. Lumsden, DeWitt, October 27, 1942
James T. Powell, Gravette, October 28, 1942
Jesse G. Hilton, Mena, November 8, 1942
Charles E. Bayan, Chester, November 27, 1942
G. Max Watkins, Walnut Ridge, November 29, 1942
Hedric Arnold Ross, Arkadelphia, December 18, 1942
William A. Snodgrass, Little Rock, January 4, 1943
Richard T. Henry, Springdale, January 4, 1943
George W. Ringgold, Gould, January 26, 1943
James M. Lemons, Pine Bluff, February 3, 1943

Charles Augusta Caldwell, Blytheville, February 8, 1943
Arthur Lee Goatcher, Plumerville, February 25, 1943
Howard Paxton Collings, Hot Springs, March 4, 1943
Flem D. Smith, Blytheville, March 27, 1943.
N. E. Murphey, Clarendon, April 15, 1943

MEMORIAL ADDRESS

It is a custom to set aside a brief period in each year when services are held in memory of the members who have finished their course and have taken that last journey to their home beyond. In this world where all things are so rushed, we are apt to forget those who were near and dear to us unless we have a regular time for such services, so it is a privilege for me today to be able to speak at the Memorial Services for the former members of the Arkansas Medical Society.

We have met as friends, as neighbors, and as comrades in the March of Life to pay our respects to those who have travelled before us to their reward.

Our thoughts and feelings towards the event of passing to the great beyond have greatly changed in the past few years, and people generally, the world over do not look upon it with the dread that was common in former years. Instead of considering passing to your reward as the end of all hopes and achievements, we think of it as the beginning of a new life in another sphere.

Whatever our faith, whatever our religion, the great principles of life and death are the same to each of us.

This is a day of memories. With bowed heads we pause at the threshold of the future and turn and look back not to find material for regrets, but to dwell upon those things which are beautiful.

It is the great Physician who cures where medicine will not restore, nor surgery heal. It is the great Comforter who gives rest and peace where life has offered strife and suffering. To those of us remaining, it brings a sense of loneliness through the absence of friendly faces and gentle handclasps. It deprives us of wise counselors and stalwart warriors. But it leaves in its places the thoughts of the long lives well spent in doing something for suffering humanity.

"They never quite leave us, our friends who have passed
Through the shadows of death to the sunlight above;
A thousand sweet memories are holding them fast
To the places they blest with their presence and love."

Since we last met in Hot Springs 37 of our comrades have passed into the Great Beyond. So while we mourn for those who are gone, we should rejoice for the many good things with

which we are blessed in life and make the most of our surroundings as we go along, for we are living in the most glorious country and the most glorious age this world has ever known.

The sextette gave another selection.

Rev. Fred R. Harrison gave the benediction.

FINAL SESSION HOUSE OF DELEGATES

Tuesday Afternoon, April 20th, 1943

The meeting was called to order at 1:30 P. M. by President Robins.

The Secretary called the roll of delegates.

The following delegates and members seated as delegates by action of the House of Delegates were present:

ARKANSAS—S. A. Drennen; BOONE—J. G. Gladden; BRADLEY—W. J. Hunt; CHICOT—J. H. Burge; CLARK—Joe W. Reid; CRAIGHEAD-POINSETT—J. H. McCurry, L. H. McDaniel; CRAWFORD—S. D. Kirkland; CROSS—J. S. Miller; DESHA—H. T. Smith; FAULKNER—N. E. Fraser; FRANKLIN—W. C. Porter; GARLAND—Geo. B. Fletcher, H. King Wade, W. T. Wootton; INDEPENDENCE—W. J. Ketz; JEFFERSON—Fred Hames; LAWRENCE—J. C. Land; LINCOLN—C. W. Dixon; LONOKE—S. S. Beaty; MILLER—R. R. Kirkpatrick; MONROE—E. D. McKnight; NEVADA—A. S. Buchanan; OUACHITA—S. A. Thompson; PHILLIPS—J. T. Herron; POLK—B. H. Hawkins; POPE-YELL—A. B. Tate; PULASKI—A. G. Cazort, H. R. Allen, Fred W. Harris, M. E. McCaskill, C. A. Rosenbaum, W. B. Grayson; SALINE—L. J. Harrell; SEBASTIAN—S. J. Wolferman; SEVIER—M. L. Norwood; ST. FRANCIS—J. O. Rush; UNION—A. D. Cathey, P. H. Muse; WHITE—G. C. Burton.

Other members of the House of Delegates present were:

President Robins, President-Elect Allbright, Vice-President Drennen, Councilors F. H. Jones, L. T. Evans, J. O. Rush, S. W. Douglas, B. L. Moore, Geo. B. Fletcher, Jos. F. Shuffield, J. F. John, and Clyde McNeil; Past-Presidents E. E. Barlow, A. S. Buchanan, O. J. T. Johnston, H. Fay H. Jones, L. J. Kosminsky, M. E. McCaskill, F. O. Mahony, M. L. Norwood, H. T. Smith, S. J. Wolferman, and W. T. Wootton and Secretary W. R. Brooksher.

A. S. Buchanan presented the report of the Nominating Committee as follows:

President-Elect—Jos. F. Shuffield, Little Rock; L. H. McDaniel, Tyronza, and R. R. Kirkpatrick.

First Vice-President—Bryce Cummins, Little Rock.

Second Vice-President—J. C. Land, Walnut Ridge.

Third Vice-President—B. L. Moore, El Dorado.

Treasurer—Paul L. Mahoney, Little Rock.

Secretary—W. R. Brooksher, Fort Smith.

Delegate to the American Medical Association—W. R. Brooksher.

Councilor, First District—P. W. Lutterloh, Jonesboro.

Councilor, Third District—J. O. Rush, Forrest City.

Councilor, Fifth District—S. A. Thompson, Camden.

Councilor, Seventh District—H. King Wade, Hot Springs National Park.

Councilor, Eighth District—M. J. Kilbury, Little Rock.

Councilor, Ninth District—J. G. Gladden, Harrison.

The Secretary called attention to the omission of a nominee for Alternate to the American Medical Association. A. S. Buchanan, from the floor, nominated R. B. Robins, Camden.

L. H. McDaniel was recognized, expressed appreciation for nomination for election as President-Elect, and asked that his name be withdrawn.

R. R. Kirkpatrick was recognized, expressed appreciation for nomination for election as President-Elect, and asked that his name be withdrawn.

By motion (Dixon-Ketz) the report of the Nominating Committee was accepted subject to withdrawal of the names of L. H. McDaniel and R. R. Kirkpatrick, nominees for President-Elect.

By motion (Kosminsky-Barlow) the House of Delegates elected all nominees by acclamation.

S. J. Wolferman presented the report of the Reference Committee.

REPORT OF REFERENCE COMMITTEE

1. We accept the report of the counsel and commend him for his general activities.
2. The report of the Secretary is to be commended and we praise him for his constructive paper and for his hard work on behalf of the Society.
3. The report of the Treasurer shows all accounts balanced and finances in excellent condition. We suggest that any excess funds be invested in War Bonds by the Council.
4. In three reports received by this Committee it has been recommended that the American Medical Association establish and maintain a Bureau of Medical Information in Washington. Inasmuch as this involves certain tax and legal questions, this Committee makes no recommendations but advises our delegates to the American Medical Association to be guided by the information obtained at the June meeting of the House of Delegates in Chicago.
5. We highly commend the report of the Committee on Mental Hygiene. Particularly do we commend the new system of admission allowed by a recent act of the Legislature. We deplore the efforts to move the entire institution from Little Rock because competent medical advice and consultations could not be obtained elsewhere. Further, the medical school would be deprived of valuable clinical material for instruction.
6. We agree with the Committee on Industrial Health and urge the county societies to give more active cooperation in this matter.
7. We accept the report of the Committee on Public Relations and earnestly suggest that the county

societies carry out these recommendations where possible.

8. We accept and appreciate the excellent report on Hospitals and Medical Education.
9. We wish to thank the Committee on Scientific Program. Considering transportation and the war difficulties, the program is excellent and speaks for itself.
10. We accept and commend the report of Dr. A. C. Shipp and his Committee for their excellent work on tuberculosis. We wish to thank Governor Adkins for the appointment of a tuberculosis commission.
11. Regarding commissions, we recommend that a medical advisory committee be established by this Society to advise with the Governor and heads of our state charitable institutions where medical interests are involved.
12. We suggest that the Legislative Committee sponsor a bill at the proper time, requiring each student in a state supported school to present a competent certificate showing freedom from contagious or infectious disease before being allowed to enter such school.
13. We accept the report of the Committee on Post-graduate Work and agree that such work should be postponed for the duration of the war.
14. We commend the excellent work of the Committee on Cancer Control. We urge that this work be kept up with all possible energy.
15. We commend the Legislative Committee, and particularly the chairman, for their fine work throughout the recent legislative session. We are confident that no man has ever done a better job in this connection than the chairman.
16. We accept the Medical Economics Committee report with this exception. We do not endorse only independent insurance companies, but feel that mutual nonprofit, lay or medical, organizations, can carry on the same work, as well, and in some instances, better than others.
17. We accept the report of the Committee on Public Health and commend Dr. Grayson for his excellent work under such trying conditions.
18. We accept the report of the Committee on Maternal and Child Welfare, and recommend that the care of servicemen's wives and children be left in the hands of Dr. Grayson and his technical advisory committee, along with the Committee on Maternal and Child Welfare.
19. We read with interest the report of the Committee on Syphilis and suggest that the Legislative Committee sponsor premarital examinations when it is deemed advisable. In this connection, we strongly urge that all pregnant women have serological examinations.
20. We accept the report of the Delegates to the American Medical Association and thank them for their work.
21. We commend the report of the State Board of Examiners. Recommendations concerning possible changes are made under the President's Address.
22. We enthusiastically thank President Robins for his excellent year's work. His first recommendation we heartily approve. This has reference to the election of the President-Elect. An amendment on this subject will be introduced following this report. Also we approve his second recommendation, regarding the President-Elect as a member of the Council, and have an amendment to be introduced on this matter. We heartily agree with his recommendations that a

full time executive secretary be employed by the State Board of Examiners, and that a permanent office be maintained in Little Rock with the records stored in the State House. However, our recommendations are that this move be held in abeyance until such time as the income of the State Board of Examiners may be sufficient to employ a member of this Society full time for this work. We commend his suggestions that a medical advisory committee be appointed to work with the Governor and other constitutional legal authorities on all medical matters connected with our state institutions. We have already made this recommendation above.

S. J. Wolferman, Chairman

E. D. McKnight

S. A. Thompson

By motion (Wolferman-Rush) the report of the Reference Committee was adopted.

H. T. Smith presented the resolution of the Courtesy Resolutions Committee.

RESOLUTION

We, your Committee on Courtesy Resolutions, beg to submit the following report:

Be it resolved that we extend our thanks to the following:

1. Pulaski County Medical Society, for their splendid cooperation and hospitality in making our state meeting one of the outstanding meetings for several years.
2. We want to thank our distinguished guests for the excellent lectures given us.
3. We want to thank the hotels and restaurants for the splendid way they have handled our hotel arrangements under the difficult times that now confront us.
4. We want to thank the newspapers for their splendid cooperation in making known our program and helping us to make our state meeting a success.
5. Last, we would like to thank the exhibitors for their splendid arrangement of scientific and other exhibits.

H. T. Smith

L. T. Evans

By motion (H. T. Smith-Barlow) the resolution was adopted.

S. A. Thompson presented the constitutional amendments proposed by the Reference Committee, which were received.

Proposed amendment to the By-Laws of the Constitution of the Arkansas Medical Society as follows:

Chapter V. Section I.

To amend the fifth sentence which now reads:

"The committee shall report the result of its deliberations to the House of Delegates in the shape of a ticket containing the names of the three members for the office of President-Elect and of one member for each of the other offices to be filled at the Annual Session."

To read:

"The committee shall report the result of its deliberations to the House of Delegates in the shape of a ticket containing the names of two or more members for the office of President-Elect and of one member for each of the other offices to be filled at the Annual Session."

Proposed amendment to the By-Laws of the Constitution of the Arkansas Medical Society:

To amend the first sentence of Section 2, Chapter VI

of the By-Laws which now reads:

"The President-Elect shall be a member ex-officio of the Council and the House of Delegates without the power of voting."

To read:

"The President-Elect shall be a member of the Council and the House of Delegates."

This is to conform with a previous amendment of the Constitution adopted last year which made the same change in Article VI of the Constitution.

By motion (Evans-H. T. Smith) the following were elected honorary members of the Society: J. S. Jenkins, Pine Bluff; C. A. Archer, DeQueen; E. H. McCray, Malvern, and J. H. McCurry, Cash.

By motion (Evans-McCurry) the following nominees for appointment to fill expiring terms on the State Medical Board of the Arkansas Medical Society were confirmed:

First Congressional District—Robert Haley, Jr., Paragould; Ira W. Ellis, Monette; H. B. Hull, Mammoth Spring.

Fourth Congressional District—L. J. Kosminsky, Texarkana; R. C. Dickinson, Horatio; Pierre Redman, Mena.

Fifth Congressional District—Robert Hood, Russellville; W. L. Brittain, Conway; Fred W. Harris, Little Rock.

By motion (Barlow-Land) the House of Delegates adjourned.

FINAL GENERAL SESSION April 20th, 1943

Immediately following the adjournment of the final session of the House of Delegates, the final general session was called to order by President Robins.

The following Past-Presidents came to the rostrum: M. L. Norwood, M. E. McCaskill, H. T. Smith, L. J. Kosminsky, A. S. Buchanan, Geo. B. Fletcher, E. E. Barlow, O. J. T. Johnston, S. J. Wolferman, and W. T. Wootton.

L. J. Kosminsky and H. T. Smith escorted Sam J. Allbright to the rostrum.

President Robins: "Gentlemen, the time has now come when it is my privilege, my duty, to present the gavel to my successor. I do this with the full knowledge that it will rest in able hands. President Allbright, I present this gavel with my best wishes for a most successful year."

President Allbright: "I accept this token of authority with a great deal of reticence. While I have had a whole year to think over what I would say now, I find it has left me. I first

attended a meeting of the Arkansas Medical Society thirty years ago and since then I have missed but two meetings. Many of the presidents who have served you in that time have passed on; the others are here behind me. I assure you, that with your help, I shall do my best to prove worthy of the traditions set by these Past-Presidents."

L. H. McDaniel and R. R. Kirkpatrick escorted President-Elect Jos. F. Shuffield to the rostrum, where he was introduced by President Allbright.

President-Elect Shuffield: "You have honored me most greatly with this highest honor. I am not ungrateful but I enter upon my duties with fear and trembling. With your help I shall do a fair job of it. I am especially grateful for the spirit of the other nominees and of the House of Delegates in electing me by acclamation."

The Past-Presidents then spoke to the Society.

Mrs. L. G. Fincher, President, Woman's Auxiliary to the Arkansas Medical Society, presented Mrs. Frank N. Haggard, President, Woman's Auxiliary to the American Medical Association, who spoke to the session.

Jos. F. Shuffield presented the invitation of the Pulaski County Medical Society for the Society to meet in Little Rock in 1944.

By motion (McNeil-Dixon) the invitation was accepted.

By motion (Land-Rush) the Society adjourned sine die.

REGISTRATION—1943 ANNUAL SESSION

ARKANSAS—S. A. Drennen, Arthur Fowler, E. B. Swindler, R. H. Whitehead; ASHLEY—M. C. Crandall; BENTON—G. A. Hughes, Clyde McNeil; BRADLEY—W. J. Hunt; BOONE—J. G. Gladden, D. L. Owens; CARROLL—A. L. Carter, J. F. John, D. K. McCurry; CHICOT—E. E. Barlow, J. H. Burge, S. W. Douglas; CLARK—J. P. Bremer, Joe W. Reid; CLAY—F. H. Jones. COLUMBIA—H. M. Kitchens, John H. Wilson; CRAIG-HEAD-POINSETT—J. H. McCurry, L. H. McDaniel, Ira Ellis, P. W. Lutterloh, H. A. Stroud; CRAWFORD—S. D. Kirkland, O. J. Kirksey; CRITTENDEN—R. B. Hamilton, B. M. Stevenson; CROSS—A. F. Barr, J. S. Miller; DALLAS—J. E. M. Taylor; DESHA—H. T. Smith; DREW—J. P. Price; GARLAND—Geo. B. Fletcher, L. G. Martin, A. H. Tribble, H. King Wade, W. T. Wootton; FRANKLIN—W. C. Porter; FAULKNER—Doris A. Baldrige, C. H. Dickerson, N. E. Fraser, J. S. Lieblong, E. T. Williams; GREENE—R. J. Haley; HOT SPRING—H. L. Brown, W. G. Hodges, R. V. McCray, M. D. Prickett; INDEPENDENCE—L. T. Evans, O. J. T. Johnston, W. J. Ketz, J. T. Matthews; JACKSON—J. B. Ivy, O. A. Jamison, E. L. Watson; JEFFERSON—W. H. Bruce, Fred Hames, J. S. Jenkins, E. C. McMullen, M. A. Shelton; JOHNSON—S. M. Graves, Geo. L. Hardgrave, Earle H. Hunt, G. R. Siegel; LAFAYETTE—R. L. Armstrong, A. W. Keith; LAWRENCE—R. S. Faircloth, H. B. Hull, J. C.

Land; LINCOLN—C. W. Dixon; LONOKE—S. S. Beaty, J. F. Brewer, E. A. Callahan, J. B. Wells, A. C. Watson, Sr.; MILLER—Wm. Hibbitts, R. R. Kirkpatrick, L. J. Kosminsky, C. S. Laws, B. C. Middleton, H. E. Murry, R. R. Robins, J. B. Tate; MONROE—W. L. Boswell, E. D. McKnight; NEVADA—A. S. Buchanan, W. H. B. Pool; OUACHITA—R. C. Kennerly, B. V. Powell, J. S. Rinehart, R. B. Robins, R. R. Robins, H. F. Thompson, S. A. Thompson; PHILLIPS—J. W. Butts, J. T. Herron; POLK—B. H. Hawkins, Pierre Redman; POPE-YELL—W. E. Ballenger, Robt. Hood, Roy I. Millard, F. E. Rushing, J. M. Stanford, A. B. Tate, W. O. Young; PRAIRIE—J. R. Lynn, T. G. Porter; PULASKI—Hoyt R. Allen, Jeff Banks, R. M. Blakely, Robert W. Boyle, C. M. Brooks, Robt. Caldwell, F. W. Carruthers, Alan Cazort, D. T. Cheairs, A. C. Clark, A. S. J. Clarke, J. N. Compton, K. W. Cosgrove, J. B. Crawford, Bryce Cummins, E. O. Day, E. J. Easley, P. C. Eschweiler, R. M. Eubanks, L. L. Fatherree, Theo. Freedman, P. M. Fulmer, S. C. Fulmer, Oscar Gray, W. B. Grayson, F. W. Harris, J. Harry Hayes, C. R. Henry, H. A. Higgins, N. T. Hollis, L. G. Holt, H. W. Hundling, Glenn Johnson, H. Fay H. Jones, J. E. Jones, M. J. Kilbury, Agnes C. Kolb, A. C. Kolb, B. T. Kolb, W. A. Lamb, W. C. Langston, Geo. V. Lewis, M. E. McCaskill, Paul L. Mahoney, C. B. May, M. M. Melson, O. C. Melson, Pat Murphey, Vernon Newman, R. Q. Patterson, L. D. Reagan, G. W. Reagan, B. James Reaves, C. C. Reed, Jr., B. A. Rhinehart, D. A. Rhinehart, B. L. Robinson, C. A. Rosenbaum, R. E. Rowland, W. L. Sadler, S. M. Sanford, W. J. Schwarz, A. C. Shipp, Randolph Smith, Jos. F. Shuffield, H. S. Stern, J. A. Summers, D. M. Switzer, Geo. Thompson, Chas. Wallis, A. C. Watson, Jr., Robert Watson, V. T. Webb, L. A. Wilcox, E. H. Wilkes; RANDOLPH—J. R. Loftis; SALINE—L. J. Harrell, M. G. Lawson; ST. FRANCIS—H. L. McClendon, J. O. Rush; SEARCY—E. A. Bing, J. O. Cotton, E. G. Fendley, H. J. Hall, J. O. Leslie; SEVIER—C. A. Archer, R. C. Dickinson, C. E. Kitchens, M. L. Norwood; SEBASTIAN—W. R. Brooksher, D. W. Goldstein, C. W. Hall, Chas. S. Holt, E. E. Holt, I. F. Jones, E. C. Moulton, J. D. Riley, B. L. Ware, S. J. Wolferman; UNION—O. L. Atkinson, A. D. Cathey, F. O. Mahony, B. L. Moore, J. A. Moore, P. H. Muse, W. A. Snodgrass, Jr., D. E. White; WASHINGTON—E. F. Ellis, W. H. Mock; WHITE—S. J. Allbright, Geo. C. Burton, A. J. Dunklin, M. C. Hawkins, Jr., W. H. Wilson.

Total attendance: Members—226. Visitors—114. Exhibitors—17. Total—357.

RANDOM THOUGHTS OF THE SECRETARY

April 30th. Tonight to see Jack Lamb's showing of his motion pictures of Alaska finding the photography of the usual excellent grade but Jack himself less retiring and modest than on former visits. Later, in the exclusive company of airplane pilots, to a preview of "Air Force" which recounts the adventures of the "Mary Ann" and does not stir our ambitions to fly any B-17s.

May 4th. For a decided change, motoring to Conway this afternoon, where many are assembled to discuss the medical care situation in that city, possessed of a considerable unanimity of thought in their desires. Surprisingly, we meet Councilor McNeil on his way home from the 1943 annual session. Later, visiting with President-Elect Shuffield obtaining the impression that he is just as proud a "grandpappy" as are Sam Thompson and King Wade. Homeward during the night in the

pre-war manner, hearing the same news 19 times on the radio but fascinated by the myriad fireflies flitting over the fields who get around much like a procurement and assignment chairman and possibly accomplish as much.

May 9th. Without regard to the deluge of rain Prairie Grove turns out to greet the procurement and assignment service and while the speakers are few, we do not find it difficult to gauge the sentiment of the gathering.

May 10th. Plagued this day and for no telling how many days to come with a fractured rib, our second fracture within a short space of time, and we wonder if we are to become an orthopedic problem. Years ago as a football player we had our first broken rib and we are forced to the painful conclusion that we were more resilient and considerably more youthful on that occasion.

May 11th. To record-breaking levels climbs old man river and that appointment as medical disaster relief chairman which we so nonchalantly accepted last fall puts us to work in earnest overseeing the health problems of several hundred refugees. Thanks to splendid support of Jim Johnson, Chamberlain, Even and Goldstein (serving in his specialist capacity) this is speedily organized and operates smoothly.

May 12th. Presiding tonight as nurses graduate, this group eager and enthusiastic, as are all graduates, to meet the world on what they are pleased to think is an equal footing.

May 16th. Comes Buckelew's song of the medical corps from out Utah way and we will be one to plug this at festive occasions to make it as well known as the air corps ballad. Write for a copy and try it out on your piano.

May 18th. When one group of our citizens, led by one individual, can set themselves apart and make a patronizing concession to engage in the war effort for another two weeks, it seems about time for America to GET TOUGH!

COMMUNIQUE

April 24, 1943,
Co. B, 45th Med. Bn.,
Indiantown Gap Military Reservation,
Pennsylvania.

To the Editor:

Just received the February issue of The Journal and am looking forward to receiving the March, April and May issues.

All is well. Best regards to all.

Note change of address and keep the Journals coming.

Sincerely,

Lt. C. L. Weber, M. C.

WOMAN'S AUXILIARY PAGE

The Woman's Auxiliary to the Pulaski County Medical Society met on April 14th with Mrs. R. T. Smith. Mrs. Carl A. Rosenbaum, President, presided over the meeting which was limited to discussion of Auxiliary business.

The Treasurer reported a total membership of 102, which included 22 members whose husbands are in the Armed Forces. After the report of the Nominating Committee, the following officers were elected: President, Mrs. R. T. Smith; President-Elect, Mrs. Paul G. Autry; First Vice-President, Mrs. L. A. Law; Second Vice-President, Mrs. W. C. Langston; Secretary, Mrs. Howard S. Stern; Treasurer, Mrs. J. Harry Hayes; Publicity Secretary, Mrs. Homer A. Higgins; Historian, Mrs. J. P. Runyan; Parliamentarian, Mrs. C. E. Witt.

Mrs. R. T. Smith announced the schedule of the sessions of the joint meeting of the State Medical Society and the State Medical Society Auxiliary to be held in Little Rock on April 19-20 and urged that all members attend the open meetings, the luncheon and the dinner to be on those days at the Hotel Marion. Delegates and alternate delegates were appointed to represent the Auxiliary at this convention.

Woman's Auxiliary to the Bowie-Miller Medical Auxiliary met April 30th at the home of Mrs. N. B. Daniels, with Mrs. Norma Day as guest speaker. Mrs. Day talked on England, bringing out many interesting and novel facts about the country in which she was a resident for ten years.

Preceding Mrs. Day's talk, a business session was held, when Mrs. L. J. Kosminsky, newly-installed State President, gave an outline of plans for the year of the State organization. Mrs. William Hibbitts and Mrs. Harry Murry reported on the recent State meeting to which they were delegates.

Mrs. Ralph Cross reported on the cancer control drive, reporting a balance in the treasury of \$93 for this work.

A social hour followed the program, when cake and ices were served from a table centered with pink and red radiance roses. Mrs. C. H. Franck and Mrs. Kosminsky presided at the table. The home was decorated throughout with vases and bowls of roses. Mrs. Daniel was assisted with the hostess duties by Dr. Spinka, co-hostess.

Radio talks concerned with the prevention and control of cancer are being delivered every day this week at 2:45 p. m. over station KCMC by member of the Bowie-Miller Medical Auxiliary who are taking advantage of a congressional resolution designating April as Cancer Control Month.

In addition to the radio talks, the Auxiliary is distributing educational literature and posters on the subject, explaining the cause and control of cancer to those who otherwise would not know of them and teaching those not yet in the cancer age group how they may protect themselves from the dread disease as they grow older.

The Auxiliary is taking an active part in supporting the annual enlistment campaign of the Women's Field Army, American Society for the Control of Cancer, which is conducted each year during April very much as is the annual Red Cross roll call. Every person is invited to contribute financially to the work in his State. The enlistment fee is one dollar, but any amount may be given.

"The Women's Field Army is an organization of the



MRS. L. J. KOSMINSKY

Texarkana
President

Woman's Auxiliary to the Arkansas Medical Society
1943-1944

women of America, regardless of race, color, creed, social or economic class, for the sole purpose of reducing the number of cancer deaths through a comprehensive educational program for the prevention and control of cancer," a member of the Auxiliary explained. "It was organized in 1936 by the American Society for the Control of Cancer, which has a record of 27 years of educational work in this field. The program has also been endorsed by the American Medical Association and by each of the 46 constituent State medical societies and State departments of health where the program is now in operation. More than 625 State and local organizations cooperate in the program.

"With its educational campaign the Women's Field Army seeks to reach all individuals and groups, so far as possible, so that in time the facts about cancer will be known fully to the general population. Probably 75 per cent of all cancer patients now seek medical help only after they have reached the incurable state. If the Women's Field Army program were directed toward caring for hopeless cases, little headway would be made in stopping the constant flow of patients into the incurable class. Hence it places major emphasis on education of the individual as to the early symptoms of cancer, how he may detect them and take advantage of the warning they give, and what he can do to prevent development of cancer in his own body. In this way thousands of lives can be saved."



Such language!

My boss used to be as grumpy as a bear. He'd growl and bang around and his wife said: "Poor George, he's working too hard. It's wearing him down to a frazzle!"

So, I told her a few plain facts:

... how I'd discovered the most amazing thing ... that physicians who prescribe S-M-A* actually have more time for other things ... because it isn't necessary to change the formula throughout the entire feeding period. (She sat up at that.)

... how S-M-A eliminates many unnecessary questions that mothers usually ask about other modified milk formulas.



When I had finished, she said she would certainly speak to George about using S-M-A as a routine formula.

★ ★ ★

Just because my boss turned over a new leaf ... he wants everybody to pat him on the back for it. But he's not fooling us ... we know how he got to be such a nice man.

**BUSY
DOCTORS
TODAY—
PRESCRIBE
S-M-A!**

With the exception of Vitamin C ... S-M-A is nutritionally complete. Vitamins B₁, D and A are included in adequate proportion ... ready to feed. Their presence in S-M-A prevents the development of subclinical vitamin deficiencies ... because the infant gets all the necessary vitamins right from the start.

S-M-A has still another highly important advantage not found in other modified milk formulas. It contains a special fat that resembles breast milk fat ... resembles it chemically and physically—according to impartial laboratory tests. S-M-A fat is more readily digested and tolerated by most infants than cow's milk fat.

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MEASURE OF POWDER
TO EACH OUNCE OF
WARM, BOILED WATER,
COMPLETES THE
FORMULA ...
TWENTY
CALORIES TO
THE OUNCE



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S-M-A, a trade-mark of S. M. A. Corporation, for its brand of food especially prepared for infant feeding—derived from tuberculin-tested cow's milk, the fat of which is replaced by animal and vegetable fats, including biologically tested cod liver oil; with the addition

of milk sugar and potassium chloride; altogether forming an antirachitic food. When diluted according to directions, it is essentially similar to human milk in percentages of protein, fat, carbohydrate and ash, in chemical constants of the fat and physical properties.

BOOK REVIEWS

The March of Medicine: The New York Academy of Medicine Lectures to the Laity. Pp. 217. 11 illustrations. Price \$2.50. New York: Columbia University Press, 1942.

These essays, six in number, represent the efforts of the New York Academy of Medicine to bring to the public a knowledge of the progress of medicine by annual lectures. The present volume contains the 1942 lectures which are most interesting to public and profession alike. Of particular importance at this time are the discussions of the B-vitamins and of nutrition.

Military Surgical Manuals, Volume V—Burns, Shock, Wound Healing and Vascular Injuries: Prepared under the auspices of the Committee on Surgery of the Division of Medical Sciences of the National Research Council. 272 pages with 82 illustrations. Philadelphia and London: W. B. Saunders Company, 1943. Price \$2.50.

This manual, one of a series published for the guidance of the military medical officer, will prove of value to the civilian physician. The local and systematic treatment of burns, with a chapter on skin grafting, provides a concise summary of latest thought in this field. The sections on shock and wound healing are similarly well-written and will prove of interest to the home front physician.

Clinical Diagnosis by Laboratory Methods: By James Campbell Todd, Ph.B., M.D., late Professor of Clinical

Pathology, University of Colorado, School of Medicine; and Arthur Hawley Sanford, A.M., M.D., Professor of Clinical Pathology, University of Minnesota (The Mayo Foundation) Head of Division on Clinical Laboratories, Mayo Clinic. Tenth Edition, thoroughly revised. 911 pages with 380 illustrations, 32 in colors. Philadelphia and London: W. B. Saunders Company, 1943. Price \$6.00.

This standard text of clinical laboratory methods and procedures appears in the tenth edition including all the old tried procedures with the addition of the more recent methods of proven value. This text continues to be of the utmost value in its field.

Manual of Industrial Hygiene and Medical Service in War Industries: Issued under the auspices of the Committee on Industrial Medicine of the Division of Medical Sciences of the National Research Council. Prepared by the Division of Industrial Hygiene, National Institute of Health, United States Public Health Service. A composite book with 16 contributors. Edited by William M. Gafafer, D.Sc. 508 pages with 20 illustrations. Philadelphia and London: W. B. Saunders Company, 1943. Price \$3.00.

This volume well discusses industrial hygiene describing in sufficient detail, industrial plant medical departments and their operation. Other sections are devoted to the prevention and control of disease in industry, sanitation and the manpower problem. This is a book to be read by all physicians who have but a slight connection with industrial medical problems. For those, more actively engaged in industrial medicine, it is a text for study.

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No. 2

WAR AND MEDICAL EDUCATION * †

J. H. MUSSER, M. D.

It is a trite remark to say that war has affected profoundly the lives of all of us. Each and every one of us appreciates that we are in a war, some more than others, but there is no one of us whom the war has not touched in one way or another. Those most deeply affected are those persons whose husbands, brothers and members of the family have gone overseas. Less deeply and profoundly affected are the persons who are struggling with food rationing, with gasoline shortage, with high income taxes and other difficulties more or less intangible, that are, at the worst, only an inconvenience. Fortunate indeed, are we who will never hear the sound of cannon, nor the explosion of a bomb. Our lives are not nearly as affected as those of the peoples of other warring countries.

One of the very radical dislocations of our way of living has to do with education. For the boys who have attained the age of 18, further continuation of studies is definitely out for the duration of the war. There are a few students in this country who will not be so affected, these are the men who are studying for the ministry or preparing themselves for professional careers in the fields of medicine and dentistry. A complete education will be obtained by no other group of young men in this country. It is true that again a certain limited number of men who are qualified to serve in the armed forces will receive training, decidedly limited and abbreviated, in such fields as chemistry, physics and special types of engineering, meteorology and a few other branches of science which are necessary for the continuation and maintenance of the war efforts. These men will receive training for a short period to a reasonably long period, by that I mean from a period of a few months to a period of several years.

The curricula of the medical schools will, on the whole, be changed but little, as a matter of fact

there will probably be a few hours added in subjects pertinent to war but otherwise they will be unchanged, but as I will develop in a minute or two, the time devoted to medical education will be very much more abbreviated than it is now, and a student, instead of completing his premedical and medical school studies in a period varying between seven and eight years, depending on whether he obtains a baccalaureate degree before entering into formal medical training, will, under the present plan, have 15 months devoted to premedical education and approximately 128 weeks or a period of roughly 32 months to his training in the medical school, at the end of which time he will receive his doctor's degree. In other words, instead of spending, as do most medical students, eight years in obtaining their medical degree, by this method of acceleration, the young doctor to be will become a physician in slightly over four years, a very radical departure from the present methods.

Let me revert to what might be said now as almost historical, namely the entrance of this country into war. With the marked increase of the number of men in the armed services it became necessary to supply these men with medical services. The original estimates called for 6.5 physicians per 1,000 men, but it is obvious that would exhaust the great pool of doctors in civil life in this country and that replacement could only be made through the bringing into the Army and Navy the doctors who had just graduated, and so it is necessary to carry on with the education of the medical student.

The ratio of medical officers to soldiers has been reduced as a result of approaching exhaustion of the civilian pool of doctors. The Army and Navy have been most cooperative and have virtually obligated themselves to the number of physicians to the armed service which would be equivalent to one-third of all doctors in this country. These men will go into the service and these men will die of disease and will die as battle casualties and they will have to be replaced. The only group from which they can be replaced is the graduating classes from the medical schools and of the slightly over 5,000 students who have

* Read before Public Meeting, Sixty-eighth Annual Session, Arkansas Medical Society, Little Rock, April 19, 1943.

† From the Department of Medicine, School of Medicine, Tulane University, New Orleans.

been graduated early in the past few years. About three-tenths of these men will not be able to pass the physical examination. These embryo medical officers would not be turned out in numbers sufficient to afford the proper number of replacements for the armed services. Therefore it became obvious that ways and means must be devised to have a greater number of doctors leaving the medical schools than there have been in the past. There are two ways of accomplishing this: first, the acceleration of the medical school courses and secondly, by having the medical schools accept a larger number of students than they have in the past. Concrete figures show that there will be 4,455 students graduating by March 31 of this year and by the end of the present year there will be 5,380 additional students who will complete their medical college work. These figures represent a very definite augmentation in the ranks of the medical profession and they will become increasingly large as the accelerated courses, plus the additional students taken in, reach their maximum.

The young doctor to be is in some respects extremely fortunate. In the first place the doctor and the dentist are the only professional men who will have the opportunity of obtaining their training while we are in a global war. I am excluding the relatively few veterinarians and theological students. These young students are not the only ones who are fortunate; the parents or whoever it is who pays the bills for their education, are equally fortunate. They will have supplied to them their clothing, their books, their tuition fees will be paid and if they are not quartered in dormitories but permitted to live outside of the University, they will be given \$2.50 or \$3.00 a day for subsistence, plus \$50 a month pay as an enlisted man. If they happen to be married, they will receive allowance for their wives. It should be borne in mind that these men are in the Army or Navy. They will be inducted into the Army as privates and then assigned, under the specialized collegiate training program, to a medical school for training. These men who are now in the reserve will have to resign from the reserve and then make application through proper channels for induction into the Army and subsequent and special assignment. This is the program that the men already in the medical schools will go through.

The boy who has not been accepted as a student in a medical school may make a request to be assigned under the specialized collegiate training program to a college where he may take premedical school course. These students will be selected on the basis of their previous scholas-

tic records and on the basis as well of certain tests of various kinds, such as intelligence, aptitude and so on. Those men who will be given an opportunity for professional training will be given an indoctrination course of 13 weeks and then be assigned to this medical school or that medical school, wherever vacancies exist. They will have no say on the selection at all of where they shall take their premedical and medical school training. The students in the premedical course will be completely subjected to military life; they will live in barracks, they will march to meals, they will go to bed when taps are sounded and their life will be that of a soldier at all times other than when they are taking their college work.

The curriculum for the premedical and pre-dental students comprises a period of 15 months. In this period of time he will have completed a total of 132 contact hours. This pre-professional curriculum will include: mathematics, 11 contact hours; physics, 14; chemistry, 36; biology, 21; history, English and geography, 20, and selected courses, 30 contact hours. The selected courses are in a sense comparable to electives, in that they will be based on the training, special interests and aptitude, and the facilities of the institution. Selected courses include a modern foreign language, psychology, economics, history, public administration, physical chemistry and advanced work in mathematics, physics, chemistry, or biology. In addition to the intellectual training the trainee must spend six hours a week in physical exercise and five contact hours a week in military education.

Inasmuch as a man who is on active service is not granted holidays and vacations, these will be abolished with the exception of a few days at the end of a semester for rest and relaxation, but the total amount cannot exceed 10 to 15 days a year.

It is the feeling of medical educators that 15 months is too short a time properly to prepare a man for entrance into a medical school. It should be borne in mind that these men will be younger men than those now entering the school because of the acceleration of the junior colleges and even the high schools. They feel that there is practically no opportunity whatsoever of obtaining a cultural education, that practically the entire time is to be devoted to scientific features of the education, without the opportunity of learning the humanities. It is going to take an exceptional man, incidentally, to carry through this premedical course. The work will be intensive and time-consuming. Provision is to be made for the acceptance into premedical specialized training program a much greater number of men

than eventually will enter the medical school. Even at the present time there are three times as many men taking the premedical course as will be able to get into medical colleges.

Medical schools are asked not to lower their high standards and it is hoped that standards of medical education will not have to be lowered, but it is impossible to see how it would be possible to give the men the training they have obtained in the past. The boy who has been through the premedical course will certainly have a certain amount of mental fatigue when he enters the medical school. The intellectual demands of medical school training are heavy. It is doubted, moreover, if a student can, for a period of 128 weeks, maintain a high pitch of efficiency. There will be no relaxation or release from the strain of continuous study. There is no doubt that the faculty likewise will not be able to carry on the extra burdens of teaching with the same degree of efficiency and vigor that they have in the past. Because of the depletion of the faculty it is necessary for many members of the teaching staffs to assume additional teaching responsibilities. The faculties of the medical schools have contributed as large a percentage of doctors to the armed forces as doctors in the country at large, most of them a greater percentage. Some medical schools have already depleted their faculty staff to a point which is critical. Some schools have released as many as 40 per cent or more of their clinical faculty. What is more serious, a great number of schools have released their preclinical faculty members in varying figures, even as many as 20-25 per cent. The preclinical staffs are always very much smaller than clinical and most of these men are on full time basis. Furthermore, the faculty members are doing a great deal of extramural military work and large groups of University professorial staffs are engaged in war research and war teaching. The loss of so many faculty members is a serious threat to the instruction level. It is earnestly hoped that the very few younger men who are considered essential for teaching will be able to continue with their pedagogic responsibilities because on these younger men are thrown a very goodly portion of the burden of extra teaching.

There is an additional factor which will play an important role in the lowering of the standards of training of the future practitioner of medicine. The Army and Navy will allow a boy to have a one year internship. Hospital staffs have been depleted not only of the visiting personnel but the resident staffs have been cut to the very bone and these older residents were those who

played an important part in the training of interns. The supervision of the intern group of a hospital will not be as good as it has been in the past and their instruction in the practical features of medicine will certainly be inadequate.

Already the medical school students are realizing that their training is going to be inferior to that which others have obtained in the past. They are making plans to continue their training after the war and the demands that will be made upon institutions where graduate training can be obtained will be immense. This is a postwar problem which should be given serious consideration at the present time; how best to supply additional training to the boys who graduate during war time and to the men who chronologically older, have not been engaged in active practice but have been pursuing military medical activities.

Summary

To summarize I might state that educators have insisted that the standards of medical training should not be lowered. I have tried to point out that this is a much to be desired accomplishment but I am extremely skeptical that it can be done. The young medical man graduating in time of war will not and cannot be as thoroughly carefully and fully trained as his more fortunate brother in medicine who obtained his degree in times of peace.

ANY PHYSICIAN MAY EXHIBIT "WHEN BOBBY GOES TO SCHOOL" TO THE PUBLIC

Under the rules laid down by the American Academy of Pediatrics, their educational-to-the-public film, "When Bobby Goes to School," may be exhibited to the public by any licensed physician in the United States.

All that is required is that he obtain the endorsement by any officer of his county medical society. Endorsement blanks for this purpose may be obtained on application to the distributor, Mead Johnson & Company, Evansville, Indiana.

Such endorsement, however, is not required for showings by licensed physicians to medical groups for the purpose of familiarizing them with the message of the film in advance of public showings in the community.

"When Bobby Goes to School" is a 16-mm. sound film, free from advertising, dealing with the health appraisal of the school child, and may be borrowed without charge or obligation on application to the distributor, Mead Johnson & Company, Evansville, Indiana.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

TOO often we substitute words for action. We repeat the same soul-satisfying phrases until we endow them with a magic and totally undeserved quality of being able to accomplish miracles. Miracles don't just happen. What look like miracles generally turn out to be the result of careful planning, devotion to sound principles and an unlimited amount of tenacity and hard work. The "early discovery" of pulmonary tuberculosis, by which is meant discovery of the disease in a minimal stage, is an empty accomplishment unless it can be followed by thorough treatment without delay.

BREAKDOWN IN EARLY TUBERCULOSIS

The prevalent opinion that the finding of active tuberculosis in a minimal stage warrants an excellent prognosis is true only when adequate treatment follows at once. Many of the favorable reports have come from sanatoria, where the outlook upon minimal pulmonary tuberculosis is not the same as that in the clinics at the time of the early diagnosis.

In sanatoria the number of minimal cases has not increased in direct proportion to the number of cases found on the outside. Failure to see and follow many diagnosed cases may explain the sanatoria impression. Some individuals who reach the sanatorium with minimal disease may show no unfavorable progression even though weeks or months elapsed between the time of discovery and the beginning of institutional care. These are the more resistant cases. Conversely, a significant number of patients found in surveys, and particularly among those in contact with sputum-positive tuberculosis, demonstrate low resistance and a rapid progression of their disease before sanatorium care is finally sought and obtained.

In the Henry Phipps Clinic, Philadelphia, Pennsylvania, even though the serious potentialities of minimal pulmonary tuberculosis are recognized and the physicians and nurses endeavor earnestly and persistently to overcome obstacles that prevent adequate care of these patients, results are astonishingly poor. A study of minimal cases has revealed that almost half developed progressive disease—true of both white and colored patients. Mortality figures were 25 per cent for the colored and 6 per cent for the white patients. Only one of the cases that died had obtained sanatorium care, and then only when already progressed to an advanced stage.

What causes the poor results? The dominant factors, will largely be applicable to most localities.

First, the diagnosis: It is universally accepted that the X-ray is the most efficient method. Visualizing the minimal lesion is not difficult, but evaluation of its status is not so simple or fool-proof. There are three categories: (1) lesions whose appearance indicates active, unstable disease, (2) lesions considered of doubtful significance and, (3) lesions whose X-ray appearance suggests that complete healing has occurred.

Determination of the character of a lesion is based to a large extent upon experience with previous similar lesions observed over long periods. Interpreting the objective film is a distinctly subjective procedure, and is of prime importance since it influences recommendations for treatment. Many chest experts advocate the follow-up of contact cases for a period of at least two years after known exposure ceases. It is obviously as necessary to follow for a similar period those cases in the second and third categories mentioned to insure their diagnosis of stability.

Of the nearly 50 per cent of the Institute's minimal cases that showed progression of the disease, 86 per cent developed extension within the first year, the remainder within three years. Serial X-ray studies enable the clinician to determine at the earliest time those cases in which the original estimate of the lesion's stability was faulty.

Following the diagnosis a strong rapport between physician, nurse and patient is essential. The psychological reactions of the patient to his disease and its treatment depend on the confidence he has in his medical advisers. It is diffi-

cult to convince a symptomless patient, often one who was found by survey means and not by his own seeking, to accept such "drastic" treatment as absolute bed rest. He often scoffs at the diagnosis, claims to feel well, and refuses to cooperate.

People in contact with sputum-positive tuberculosis may submit to examination merely for the comfort of being told they are free of the disease. When their hopes are dashed and they are confronted with their own unsuspected trouble, they may turn atagonistic and refuse to accept advice.

Again, society has done little to solve the problem of the family head who must leave behind a situation of destitution for the ones he loves by accepting treatment which must necessarily be a prolonged hospitalization.

Assuming that all these deterrents to treatment have been removed, the actual obtaining of hospital care is in many communities still a great problem, growing greater due to wartime shortages of materials and personnel. Institutions that require positive sputum before admitting a patient are inviting dangerous progression before making available the badly needed bed. The tendency to regard minimal cases lightly, treat them insufficiently, is far too prevalent and often leads to inexcusable relapses. Reliance on the standards of 20 years ago that call for dependence on physical signs to determine the stability of lesions defeats the whole purpose of early diagnosis surveys, since the case without clinical manifestations will receive neglect instead of treatment and close supervision it deserves.

Early diagnosis is meaningless unless it leads at once to intelligent handling, prompt care and adequate follow-up, with eventual recovery and maximum rehabilitation the goal.

Breakdown in Early Tuberculosis, Samuel C. Stein, M. D., Public Health Nursing, March, 1943.

THIS WEEK'S GOOD DEED

Why not write a letter to one or more of your colleagues now in military service? The Journal will forward all such letters if you do not have a correct address.

MORE HELP FOR MILK-ALLERGIC PATIENTS

Appetizing and nutritious recipes for using Mull-Soy in milk-free diets are now available in a new publication of Borden's Prescription Products Division. Already widely prescribed as a hypoallergenic substitute for milk in infant formulas, Mull-Soy is now proving equally useful in diets of older infants, children and adults who are allergic to milk.

Mull-Soy is an ethically-marketed soybean food in liquid emulsified form. It is palatable, readily digestible, well-tolerated, and easy to use. Although hypoallergenic in most cases of milk allergy, it nevertheless closely resembles milk in nutritional values of protein, fat, carbohydrate, and minerals. Mull-Soy ingredients are entirely of non-animal origin, consisting of soybean flour, soybean oil, soybean lecithin, dextrose, sucrose, calcium phosphate, calcium carbonate, salt, and water. After special processing at carefully controlled temperatures, the mixture is homogenized at high pressure, sealed in sanitary-type cans, and sterilized. In flavor it is slightly sweet and nutlike, and many find it makes a pleasing warm drink when simply diluted with an equal amount of hot water.

Included in the new Mull-Soy recipe folder are numerous beverages, soups, and desserts, as well as directions for using Mull-Soy in place of milk or cream for cereals, coffee, mashed potatoes, etc. Each recipe has been carefully tested in the Borden Experimental Kitchen and checked for palatability, ease of preparation, and suitability for milk-free allergy diets. A number of the recipes have several suggested variations and optional ingredients which permit greater variety in the diet and also make the recipes more useful for patients allergic to other foods in addition to milk.

These Mull-Soy recipe folders are designed for distribution by physicians to their patients. Any desired number of copies may be obtained by writing to Borden's Prescription Products Division, Department CB, 350 Madison Avenue, New York 17, N. Y.

It is well for a man to respect his own vocation, whatever it is, and to think himself bound to uphold it, and to claim for it the respect it deserves.

—Charles Dickens.

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EDITORIALS

NEED FOR MEDICAL OFFICERS

Official statements issued through Procurement and Assignment Service indicates a lag in the recruitment of needed physicians for military service in 1943. These statements follow:

Surgeon-General, United States Army—"The Army is increasing in size; more medical officers are required. New units are being formed and many general hospitals are under construction at many points in the United States. Some basic training must be given to medical officers before they are assigned to purely medico-military duties; for this reason they are needed one or two months prior to actual assignment."

Surgeon-General, United States Navy—"In order to plan intelligently I have reviewed the personnel situation in the Medical Department of the Navy. There is a deficit of approximately 900 medical officers for the next six months,

based on minimal requirements. The Bureau of Medicine and Surgery calls medical officers to active duty when billets are available, does not build up too large a reserve at any time. Consequently, procurement must go on in an orderly fashion, if we are to meet the demands that will be placed on us as the offensive fighting develops. We cannot afford to have the deficit increase beyond its present level; if it does we will not be able to give first-class medical service to our wounded. We look to the medical profession of our nation to come forward with the available doctors that can be spared from civilian life, to aid in our military necessity. In the main, the profession has responded nobly. * * * The medical profession is faced with the challenge of furnishing medical service to the armed forces and to the civilian population during the active state of the war and in the post war period, which we hope will not be too far distant. Should the profession fail in either regard many forces may develop that will destroy the practice of medicine as we know it. This would be disastrous and it is something that we cannot afford to allow to come about. In all seriousness, the doctors of medicine in the United States should take stock of their own immediate situations and should give every assistance in planning to see that medicine plays its responsible part in this and coming years."

Memorandum from Army Service Forces to Officer Procurement Districts—"The critical situation in the procurement of physicians * * * continues and is intensified."

Dr. Frank H. Lahey, Chairman, Directing Board, Procurement and Assignment Service—"We must face one inescapable fact. Our fighting men, and those who remain behind, must and will have medical care. It will be obtained one way or another. The choice of methods is still in our hands. The medical profession of this country never has failed the nation; it must not do so now."

Physicians under the age of 38 are urgently needed by the armed forces. Those under 45 who are available for military service are likewise needed in numbers to complete the requirements for the army of 1943. Physicians, previously rejected may now be accepted.

While Arkansas has maintained its quota of volunteers to the medical corps of the armed forces, those physicians whose services can be spared from their civilian duties within the state are asked to apply for appointment.

OBSTETRIC AND PEDIATRIC SERVICE FOR FAMILIES OF ENLISTED MEN

A new program for medical and hospital care of the wives and infants of enlisted men (below grade IV) has been made available in Arkansas. For the reason that the initial plan as instituted is subject to revision, such revisions having been sent to the Children's Bureau in Washington for approval, The Journal has not commented upon the features of the present plan. The Society has recommended certain changes in the now-approved plan which will extend participation to more physicians in Arkansas. For the present, physicians are asked to consult with the county health officers or with the State Board of Health on details of the program.

PROCEEDINGS OF SOCIETIES AND PERSONALS

The motion picture, "The Story of Lyovac Normal Human Plasma" was exhibited at the June 7th meeting of the Pulaski County Medical Society.

Elizabeth Fletcher, Secretary.

The Ninth Councilor District Medical Society met in luncheon session at Harrison June 2nd for the following program: "Address," S. J. Allbright, Searcy; "Aspirin Poisoning," Paul Eschweiler, Little Rock; "Thyroidectomy," J. Harry Hayes, Little Rock; "Loeffler's Syndrome," S. W. T. Cull, Little Rock, and a motion picture, "Adrenal Cortex."

The Fifth Councilor District Medical Society met in dinner session at Magnolia May 20th for the following program: "Neuro-Surgical Conditions in General Practice," Robert Watson, and "Treatment of Burns," Geo. V. Lewis, both speakers of Little Rock.

The Miller-Bowie Medical Societies met May 21st in dinner session at Texarkana for the following program: "Some Principles Involved in Repair Work in the Pelvis," C. A. Smith; "Report of the Annual Session of the Arkansas Medical Society," R. R. Kirkpatrick, and "Report of the Annual Session of the State Medical Association of Texas," J. N. White.

H. K. Abrams, Secretary.

S. J. Wolfermann has been elected surgeon of the Fort Smith post of the American Legion.

"Some Objections to Routine Circumcision," by J. W. Harper, El Dorado, appeared in the May issue of the Tri-State Medical Journal.

Dr. and Mrs. H. W. Hundling, Little Rock, spent a recent vacation in Iowa.

Lt. Ralph E. Weddington, Batesville, has been in service overseas since February.

J. W. Butt and Geo. R. Storm have been elected surgeons of the Helena post of the American Legion.

Capt. Jas. P. Jernigan, formerly of Little Rock, now stationed overseas has been awarded the Legion of Merit honor for meritorious action in the South Pacific.

C. A. Archer, Jr., formerly of Dumas, Texas, has located at Bauxite.

A. S. J. Clarke, formerly of Little Rock, has located in Conway.

Capt. Hollis H. Buckalew has been transferred from Hill Field, Utah, to School of Applied Tactics, Orlando, Florida.

Lt. Jim McKenzie has been transferred from Bowman Field, Kentucky, to Headquarters, Third Air Force, Tampa, Florida.

R. D. Dickins, Monticello, has been called to active duty as Captain, Medical Corps, Army of the United States, and assigned to 2nd A. A. F. A. F. S., Altus, Oklahoma.

H. H. Brown, Walnut Grove, is now located at Florida Parish Charity Hospital, Independence, Louisiana.

L. L. Hubener, Blytheville, spent a recent vacation in Minnesota.

E. D. McKnight, Brinkley, and L. D. Duncan, Waldron, have been reappointed to the Arkansas State Board of Health.

Lt. Ben H. Pride, Fort Smith, has been transferred from La Junta, Colorado, to MacDill Field, Tampa, Florida.

Ross Fowler, Harrison, recently addressed the Rotary Club of that city on "The Control of Cancer."

E. P. Griffin, Atkins, now stationed at La Garde General Hospital, New Orleans, has been promoted to major.

Harvey Shipp, Little Rock, now stationed at Moffett Field, California, has been promoted to lieutenant-commander.

Clyde L. McNeil, Rogers, has purchased an office building.

"The Story of Dr. Wassell" by James Hilton, recounting the experiences of C. A. Wassell, of Little Rock, in Java during the early days of the South Pacific campaign, has been published.

Capt. T. K. Mahan, Blytheville, is now on duty at William Beaumont General Hospital, El Paso, as assistant radiologist.

TETANUS IMMUNIZATION OF MILITARY PERSONNEL

All military personnel on induction are being immunized against tetanus either, as in the Army, by three injections of fluid toxoid, or as in the Navy and Marine Corps, by two injections of alum precipitated toxoid (New Eng. J. Med., 227:162, 1942). In addition a small or stimulating dose is injected prior to departure for a theater of operations and an emergency dose is given to those wounded or burned in battle or incurring other wounds likely to be contaminated with *Clostridium tetani*. According to recent report (Am. J. Pub. Health, 33:53, 1943) since June, 1941, when the present tetanus immunization program was adopted, there have been but four cases reported from the entire Army, and none of these were in immunized individuals. Although perhaps too early in the present war to draw any conclusions, it is of particular interest that no cases of tetanus have been reported from battle casualties.

For civilian use, especially in children, it is of decided advantage to accomplish simultaneous immunization against tetanus and diphtheria. Combined Diphtheria Toxoid-Tetanus Toxoid, Alum Precipitated, Lilly, is designed for prophylaxis only, affords effective immunity against both diseases, and avoids risk of serum sensitization which may follow use of an antitoxin.

RANDOM THOUGHTS OF THE SECRETARY

May 19th. To bed on the Rock Island at four this morning to sleep for three hours and then to visit with the early ones at Saint Vincent's. Mahoney takes us in tow for a bit of instruction in tonsillectomy and bronchoscopy which he does in neat manner, the bronchoscopy being of particular interest to us, accustomed as we are to varying shadows cast by bronchi on films. Paul makes no mention, however, of the time he removed one tonsil for the hospital janitor using normal saline for local anesthesia. Thence, to the Medical School where we discuss procurement with the dean but largely listen to his plans for a greater school, the fulfillment of which will mean much to medical education and medicine in Arkansas. Making our first call at the Stover establishment, we see more scarce items of professional equipment than we suspected were available and realize that Bill Stover is a real helper for Arkansas physicians. So to the Albert Pike as Hoyt Allen's guest, the hotel being in a red coupon-spending mood and piling our plate with food in pre-war fashion, as about the table there is discussion of the troubles of the dental colleagues. Off for Searcy, met by George Burton at Bald Knob, and looking over his place where there many items are of his handicraft, in particular, the Burton fracture reduction apparatus, an unique affair. At Searcy, we talk over all phases of medical care in White courtty, the discussion more free and easy when we explain that we are not looking for doctors for the army, at present. Eating a Mayfair dinner, better than on last visit, and away to Bald Knob. Late into Little Rock, Grayson kindly acts as taxi service, permitting us to board the Rocket although we can hardly say that we repaid good for good in this instance.

May 23rd. To bed in Little Rock at five this morning, travel being this difficult in flood conditions, but up at eleven and enjoying the luxury of a tub bath with plenty of water, the home town now having all sorts of water except that which comes from a faucet. Once again conferring over the intricacies of a governmental program for care of wives and infants of servicemen without a new viewpoint on the situation, and concluding the deliberations with the sending of a telegram to Washington in the now-generally accepted manner when regulations are imposed.

May 29th. Utter confusion best describes our sensations this afternoon as we withdraw our left hand from the closed car door and observe that the distal phalanx of the second finger is totally and irrevocably missing. So away to the hospital where Wolfermann does the traumatic surgery well indeed, not forgetting to apply merthiolate liberally to the stump just before the local anesthesia takes full effect. Tonight come Wolfermann, Grayson and Ross to sit up with the sick and there is much to be told.

May 30th and 31st. These days fully concerned with the realization of the degree of pain that accompanies the loss of a single phalanx.

June 1st. Still cogitating over that missing segment of finger, we conclude that removal of the car doors or the use of a jeep is doubtless a proper move on our part.

June 6th. Finally arriving Chicago we are in time for the radiologist's banquet where we sponsor Loran of the Southern Medical, making an erstwhile specialist of him, while Lockwood and Louie Allen of Greater Kansas City concern themselves more with plans for a fleeting vacation in Colorado.

June 7th. To the abbreviated session of the American Medical Association whose delegates make slight show of a meeting being in town when compared with the usual annual session crowds. Here there is much talk of representation in Washington and of medical care plans.

June 8th. Another day in Chicago and as yet we have no meat item on the menu.

June 9th. Today given over to the transaction of much business in the House of Delegates, for all of which we hope acceptance in a vigorous spirit by the profession.

June 10th. Closing the sessions, we fly to Kansas City, wondering over the care with which the plane windows are curtained on take-off and at landing, the clouds below us not permitting a view of much other than the Mississippi as we cross this up Iowa way.

June 17th. Discussing the medical care problems in Blytheville today, finding the medical profession far better represented in attendance than the laity. Sheddan gives a new slant on ethics as obtained from a negro practitioner, who, having guaranteed a cure and receiving the advance payment, stated, when cure was not obtained that it would be unethical to refund the money. Eating at another of Mississippi county's good pig stands as the guest of Atkinson and subsequently making an inspection of Blytheville's two hospitals, of which they should be justly proud. So homeward, grateful that railroad air-conditioning is not rationed.

June 20th. Once again gathering in Little Rock to confer over revisions in the suggested governmental plan for the obstetric and pediatric service to families of enlisted men, this conference having the added difficulties of a congressional action which may nullify or amplify our efforts, as who knows? Aboard the train homeward are the Hundlings in gay spirits seeking vacation.

OBITUARY

WILLIAM JEFFERSON HUTSON, age 60 years, Eudora, died June 20th. Born at Rials Creek, Mississippi, he graduated from the University of the South and completed his medical training at Memphis Hospital Medical College in 1909. In addition to his membership in the Chicot County Medical Society, the Southeast Arkansas Medical Society and the Arkansas Medical Society, he was a staff member of the Lake Village Infirmary. Surviving relatives are his wife, three daughters and five sons.

MEADE B. OWENS, age 70 years, died at his home in Newport June 20th. A graduate of the Gate City Medical College in 1903, he had practiced at Amagon and Beedeville before locating in Newport. For the past 12 years he had served as health officer for Jackson county. In addition to his membership in the Jackson County Medical Society and in the Arkansas Medical Society, he was a Fellow of the American Medical Association and a member of the Baptist church and of the Masonic lodge. Surviving relatives are his wife and a son.

WOMAN'S AUXILIARY PAGE

The Woman's Auxiliary to the Pulaski County Medical Society met May 19th for the final luncheon-meeting of the year at the home of Mrs. R. A. Law. Co-hostesses were: Mrs. W. R. Richardson, Mrs. B. A. Bennett and Mrs. R. E. Rowland.

Each Committee Chairman submitted reports of the year's achievements. Mrs. Carl A. Rosenbaum, retiring President, summed up the progress made by the Auxiliary in all projects undertaken. She recommended next year the Auxiliary establish a "Doctor's Aide Corps" such as is now being organized by wives of physicians throughout the nation. The new officers elected to serve next year were installed by Mrs. C. E. Oates: President, Mrs. R. T. Smith; President-Elect, Mrs. Paul G. Autry; First Vice-President, Mrs. R. A. Law; Second Vice-President, Mrs. W. C. Langston; Secretary, Mrs. Howard S. Stern; Treasurer, Mrs. J. Harry Hayes; Publicity Secretary, Mrs. Homer A. Higgins; Historian, Mrs. J. P. Runyan; Parliamentarian, Mrs. C. E. Witt.

Mrs. Rosenbaum expressed appreciation for the co-operation given during her Presidency and pledged her support to the new President, Mrs. Smith, who accepted the gavel with a short address in which she stated her aims for the coming year.

MY (3) DAYS

Mrs. Roosevelt would have crowded these activities into (my day), but I was privileged to take three days to report on the 21st annual meeting of the Women's Auxiliary to the American Medical Association in Chicago, assembled at the Drake Hotel, June 7th-9th.

I am very grateful to the Arkansas Auxiliary to have given me the honor of representing them and attending this convention where I hope to gain much knowledge and inspiration and return to Arkansas with a real message.

So—
Off the train, registration and then into the meeting of the Board of Directors. Mrs. Haggard, our president, presided at all meetings with dignity and efficiency.

At this meeting it was received with applause the report that "The Bulletin" was showing a gain and had paid for itself.

The Doctor's Aid Corps was presented by Mrs. Greene, of Atlanta, who appeared in her official uniform of navy blue. She outlined briefly the program of the Doctor's Aid Corps. It is my sincere desire that our Auxiliary will present a good report at the state meeting on this phase of the national program.

A state radio chairman was recommended. Mrs. Weir, of Kentucky, spoke to this point which I believe is far reaching when supplemented by the County Auxiliaries.

Since the meeting was quite streamlined the two luncheons, the tea honoring the National President, Mrs. Frank N. Haggard and Mrs. Eben J. Carey, President Elect, and the open meeting for the installation of the new President of the American Medical Association were the only social activities.

The luncheon on Monday in the Gold Coast Room celebrated also the 21st birthday of the Auxiliary. Mrs. A. J. Mix, Illinois State President, presided, and as she reviewed the history of the Auxiliary, she lit a candle in the center of the floral piece as each president's name was called; a very effective ceremony.

Honorable Edward J. Kelly, Mayor of Chicago, gave us a very warm welcome to Chicago, even though the first couple of days, the weather man gave us a cold reception.

Dr. Frank P. Hammond, Chairman of the Advisory Com-

mittee of the Woman's Auxiliary to the Illinois State Medical Society was the guest speaker, "Doctor's Wives—Medicines Strangest Ally." He particularly recommended that more doctors talk about the Auxiliary.

Monday afternoon, June 7th, the opening meeting of the House of Delegates of the Woman's Auxiliary to the American Medical Association took place in the grand ballroom.

Reverend Harrison Ray Anderson, of the Fourth Presbyterian Church of Chicago, gave the invocation. Silent tribute was paid the deceased members.

The registration committee's final report of 168, a splendid group assembled in view of the times and conditions due to the war.

Mrs. Haggard's report was outstanding. Hers was a difficult year but nevertheless she covered herself with glory.

In our Auxiliary it is interesting to know we have 25,127 paid up members, with very few lost considering the war in progress.

Mrs. Hayden, representing the U. S. Treasury, gave a very impressive and timely talk for an appeal for the purchase of War Bonds.

The Tuesday morning session took care of the reports of the standing committees and the State President's reports.

I regretted very much that Mrs. William Hibbitts was not present to read her report, which I am sure would have been a compliment to our state, as we are very proud of our National Officer.

I took pride in reading the Arkansas state report for which Mrs. Fincher, the immediate past-president, was complimented.

Business to come before the body—

The Adoption of a Loyalty Pledge, which was referred to the new officers, reading:

"I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association.

"I will support its activities, protect its reputation and ever sustain its high ideals."

It was recommended that a War Service Committee be appointed as a Standing Committee.

Membership identification cards were recommended, the issuing of which we will later be notified, the need of which was felt during the war with so many of our members changing residence.

At the Tuesday luncheon we had many distinguished guests who addressed us:

Brigadier General Fred Rankin, President, American Medical Association.

Dr. James E. Paulin, President-Elect, American Medical Association.

Dr. Morris Fishbein, Editor, American Medical Association.

Dr. Fishbein spoke on Post War Planning with 48,000 men handed a discharge, to be fitted back into civilian life, in all of which the Auxiliary can aid.

Mrs. Haggard and Mrs. Carey were made honorary commanders of the Doctor's Aid Corps.

High tribute was paid Mrs. Haggard from the Texas delegation with the presentation of a beautiful silver serving tray.

Flowers were presented Mrs. Carey upon taking office.

The president's pin presentation and installation was given by Mrs. R. E. Mosiman.

At the Board of Directors meeting, Mrs. Eben Carey, our new president, presided. I am sure the national body has made no mistake in choosing such a gracious and able person to lead us this year.

We had the extreme pleasure of having Dr. James P. Simonds address us on "The Effect of War on Medicine."

In the past students went to college, took pre-med course, scientific subjects were stressed, no limit on time for cultural subjects. Then they could enter medical school of their own choice, a mutual selection by the student and the school. After 4 years of hard and exacting work, internship, then appeared before the board to enter practice.

But now—Finish high school, record submitted to committee of army and navy what college he will enter for pre-medical education, where the student pursues an abbreviated pre-medical course. The science courses given in a limited time with no cultural subjects included. He is carefully watched and if he doesn't make the grade he is put into the armed forces. Then he is ready to enter the medical school, but he has no choice.

With this accelerated program of 3 years, then into a hospital as an interne, and may be able to serve a full year.

Now the question arises after the war, will these boys be able to go on and fit themselves for practice later on, or some may want to stay in the army?

Will the schools be allowed to go back to the old system or an accelerated program, which works a hardship on the students and the faculty?

This is food for thought for our young men who will eventually be our future doctors.

And so with hurried farewells, this ended a very pleasant meeting of the Auxiliary, anxious to return to our homes inspired to get our program out to our members for a full and profitable year of Auxiliary work.

MRS. L. J. KOSMINSKY, President.

Mrs. P. H. Phillips of Ashdown was named president of the Woman's Auxiliary of the Bowie-Miller Medical Society in its regular meeting May 21st at the home of Mrs. Harry Murry. Mrs. Phillips succeeds Mrs. C. H. Frank, retiring president.

Mrs. Frank reviewed the work of the Auxiliary the past year and thanked members for their cooperation. Mrs. A. G. Lee was given a vote of thanks for her splendid work as treasurer.

Mrs. William Hibbitts gave a report of the state board meeting held in Fort Worth in May. She reported that Bowie County had won a blue ribbon for members reading the state journal. Mrs. Hibbitts told that the past year marked the twenty-fifth anniversary of the state auxiliary.

Mrs. Frank presided over a business session, after which members were invited to the dining room, where a salad course was served with Mrs. Frank presiding at the table. The home was decorated throughout with roses, ragged robin, and shasta daisies.

Officers who will head the Auxiliary during the coming year, in addition to Mrs. Phillips are as follows: president-elect, Mrs. J. T. Robison; first vice president, Mrs. William Hibbitts; second vice president, Mrs. Reavis Pickett; third vice president, Mrs. R. R. Kirkpatrick; fourth vice president, Mrs. Joe Tyson; recording secretary, Mrs. Roy Baskett; corresponding secretary, Mrs. A. G. Lee; treasurer, Mrs. L. H. Lanier; historian, Mrs. N. B. Daniel; publicity, Mrs. E. M. Watts; and parliamentarian, Mrs. C. E. Kitchens.

Mrs. Ralph Cross, chairman of Cancer Control Committee of the local Medical Auxiliary announced Saturday that her committee had sent a cash donation of \$140.00 to the Women's Field Army for the Cancer Control fund. Mrs. Cross has been most active in this work of cancer control in Texarkana, sponsoring several radio programs, lectures before clubs, and other cancer control programs, in addition to raising funds for the work.

Dear Doctor:

A few weeks ago, you received an announcement from the KELLEY-KOETT MFG. COMPANY of Covington, Kentucky, informing you that we have been appointed their exclusive Arkansas representatives for the sales and service of KELEKET X-ray equipment and supplies.

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Our X-ray department is under the competent direction of MR. G. DAN CUMMINGS who has had many years of experience selling and servicing X-ray equipment. He will be pleased to put his years of experience at your disposal for the service of the equipment you will purchase from us in the future as well as the apparatus you now have.

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RESOLUTION

Dr. G. Max Watkins, 69, was born at Richwoods, Lawrence County. He was graduated from the Memphis Hospital Medical College in 1909 and served in World War I, enlisting as a lieutenant and was promoted to captain then to major. He was honorably discharged after serving 18 months.

He spent the greater part of his professional life in Walnut Ridge where he offered his services to rich and poor alike. He was not mercenary but looked upon his vocation as a profession wherein his first duty was to render service. In the latter years of his life he was handicapped by poor health so that he could not render as much service as he would have liked. He was genteel and dignified in his bearings, ethical and technical in his professional life. He was devoted to public health and a supporter of organized medicine. He was devoted to his aged mother, his family and his church.

Therefore be it resolved by The Lawrence County Medical Society that on Nov. 29, 1942, there went out from us a man whom we shall

miss for many years to come. A man who loved his Society and his fellow physicians. Be it further resolved that in the passing of Dr. Watkins the family has lost an adoring son, a loyal and affectionate husband, a kind and indulgent father. The town of Walnut Ridge has lost an honorable citizen.

Dr. W. W. Hatcher, President,
Dr. Charles D. Tibbels, Secretary.

BOOK REVIEWS

Urology in General Practice: By Nelse E. Ockerblad, B. S., M. D., F. A. C. S., Professor of Clinical Urology, University of Kansas School of Medicine, etc., and Hjalmar E. Carlson, B. S., A. M., M. D., F. A. C. S., Instructor in Urology, University of Kansas School of Medicine, etc. Chicago: The Yearbook Publishers, 1943.

This text concerns the field of urology as the general practitioner sees it. The authors have had approximately 40 years of experience in the specialty. The salient features of the diseases, the abnormalities and injuries of the genito-urinary tract, are rather well condensed, a service to the busy practitioner. Technical operative procedures are purposely omitted. There is full and complete discussion of sterility and impotence with all diagnostic and therapeutic measures included.

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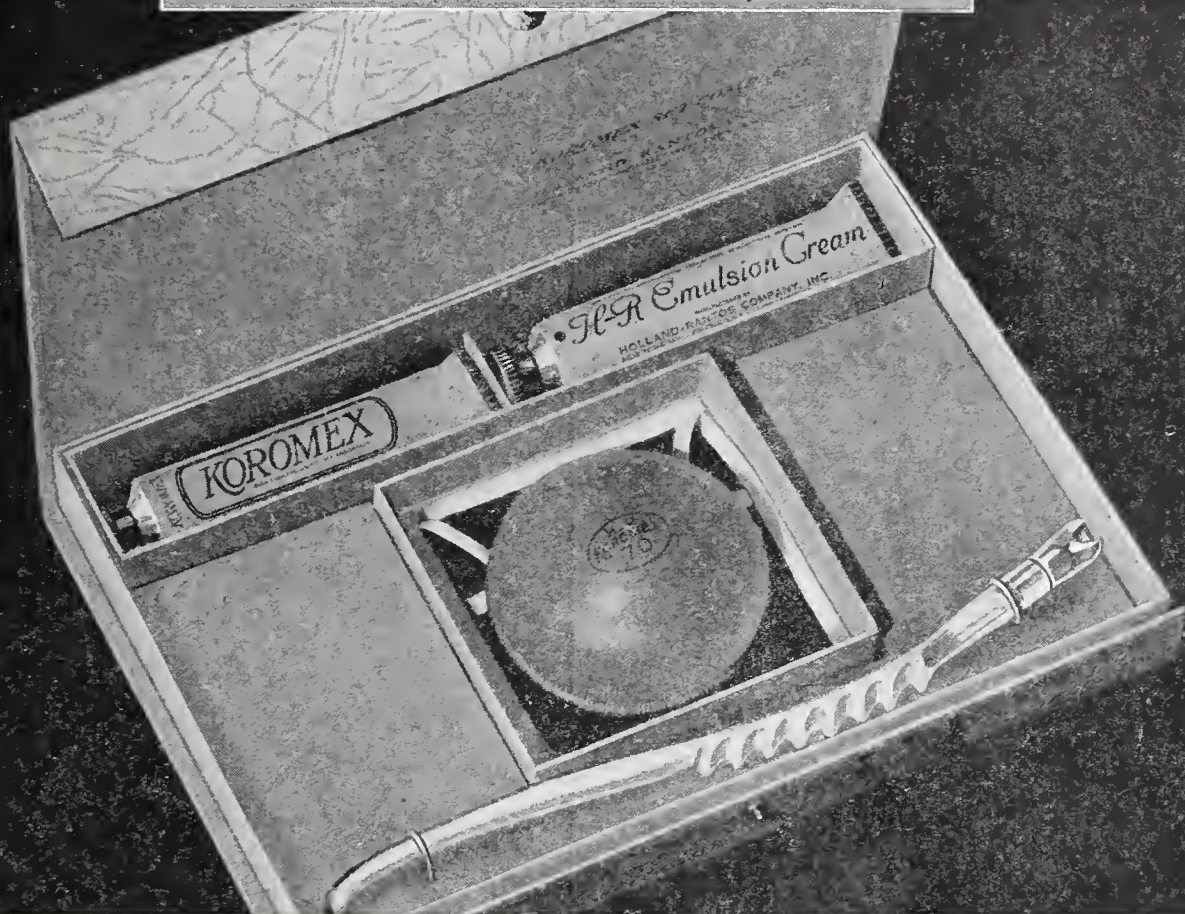
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Flying Men and Medicine: By E. Osmun Barr, M. D. Pp. 254. Price \$2.50. New York: Funk and Wagnalls Company, 1943.

This volume tells the story of aviation medicine and is particularly designed to inform the prospective flier of the medical phases of flying which determine whether he is suited, physically and mentally, how he may prepare for the examination, and how he may maintain his efficiency. It will be read with interest by anyone who is interested in becoming a pilot.

Nutrition and Diet in Health and Disease: By James S. McLester, M. D., Professor of Medicine, University of Alabama, Birmingham, Alabama. Fourth Edition, Thoroughly Revised. 849 pages. Philadelphia and London: W. B. Saunders Company, 1943. Price \$8.00.

In the past decade more and more attention has been given to the part diet plays in the role of health and disease. Under good living conditions where adequate foods are available and proper application of these foods are adhered to, nutritional disturbances are hardly ever encountered. Improper application of food stuffs, however, regardless of the quality, may result in many metabolic disturbances which the average physician will often ignore as a basic factor in arriving at a diagnosis of perplexing disorders. This new text keeps stride with the newer knowledge concerning nutrition and diet in health and disease. The chapter on vitamins has been thoroughly discussed. Newly discovered vitamins, such as cholin, biotin and pantothenic acid, have been included. The requirement of vitamins, minerals and other nutritive essentials has been included to accord with the figures given in the table of "Recommended Daily Allowances," constructed by the Food and Nutrition Board of the National Research Council. Changes in the distribution and composition of commoner foods, particularly those changes necessitated by the exigencies of war, such as the introduction of enriched flour, are discussed. An entire chapter has been devoted to infant feeding, also a section has been added on the feeding of the aged. The chapter dealing with the dietary management in deficiency diseases is particularly interesting and the text as a whole is a valuable contribution to this subject and of inestimable value to the clinician.

The Principles and Practice of Obstetrics: By Joseph B. DeLee, A.M., M.D., formerly Professor of Obstetrics and Gynecology, Emeritus, University of Chicago; Consultant in Obstetrics, Chicago Lying-in Hospital and Dispensary; Consultant in Obstetrics, Chicago Maternity Center; and J. P. Greenhill, B.S., M.D., Attending Obstetrician and Gynecologist, Michael Reese Hospital; Obstetrician and Gynecologist, Associate Staff Chicago Lying-in Hospital; Attending Gynecologist, Cook County Hospital; Professor of Gynecology, Cook County Graduate School of Medicine. Eighth Edition, entirely reset. 1101 pages with 1074 illustrations on 841 figures, 209 of them in colors. Philadelphia and London: W. B. Saunders Company, 1943. Price \$10.00.

The eighth edition of this standard work is edited by Greenhill, the subject-matter is unchanged but there has been definite condensation and avoidance of repetition. New chapters on endocrinology and X-ray pelvimetry have been added. This edition will receive the approval of the profession.



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No. 3

INDUSTRIAL DERMATOSES *

DAVIS W. GOLDSTEIN, M. D.
Fort Smith

Industrial dermatitis is a pathological condition of the skin for which occupational exposure can be shown to be a major, casual, contributing or eliciting factor.

In 1933 nine states which kept records reported 5,787 compensated occupational dermatoses (1). In a total of 8,875 occupational diseases about 65% were dermatoses. There has been a rapid increase since then. So great has been the increase that in 1936 a committee from the Dermatological Section of the American Medical Association was appointed to study industrial dermatoses. Shortly afterward a committee from the American Dermatological Association was appointed. Members of the two committees have carried on and played a large part in the development of the council on industrial health.

Arkansas has a number of war industries situated at Little Rock, Texarkana and Fort Smith. In Fort Smith we had a glider plant. I have visited this plant and observed the individuals at work. There have been a number of cases of dermatoses. Glue has been the greatest offender. This glue is in powder form and contains both formaldehyde and sulphur. Either agent could be an irritant or a sensitizer. The workers apply this glue with a brush on small strips of wood, afterward smoothing same with a cloth, which comes in direct contact with the hands and arms.

The shell plant has had fewer cases. The cutting oils cause a folliculitis and other infections. In this plant the majority of employees are Negroes. We know the Negro is less susceptible to dermatoses than is the white man or woman. The safety engineers at these plants are familiar with the cause of skin hazards and are

willing to cooperate and follow any suggestion one may make to improve conditions.

Factors influencing occupational dermatoses (2):

Race: Dark skin individuals, brunettes and Negroes are less susceptible to irritants to the skin than are blondes. Workers with much hair on their body and legs are more apt to acquire folliculitis than those with hairless skin. Workers with oily skin are more susceptible to accidents and infections. An individual with a dry skin, ichthyosis, psoriasis, or with a seborrhoeic type of skin, or any itching dermatitis, is more susceptible to irritants and sensitizers.

Perspiration: Extensive perspiration, combined with friction, macerates the skin and makes it more susceptible to irritants. The pH of perspiration affects the solvent properties of chemicals and in this manner affects the action on the skin.

Lack of Cleanliness: Lack of cleanliness as to clothing, also personal methods of cleanliness, are the most important predisposing causes of occupational dermatitis. Daily shower baths, use of non-irritating soap, clean work clothes, clean floor benches, etc., would contribute materially to the prevention.

Schwartz (3) classifies the industrial dermatoses according to the following causes:

1. Physical agents, such as burns, scalds, extreme cold, radiation, friction and trauma.

2. Primary irritants—that is, substances which will irritate any skin. These can be divided into organic or inorganic. The inorganic primary irritants can be subdivided into acids, strong alkalies and corrosives. The organic primary irritants can be divided into acids and solvents.

Specific irritants: Those do not affect every individual but cause dermatitis in a considerable percentage of hypersensitive individuals.

The specific irritants can be divided into groups (3):

- (a) Oils and greases, such as lubricating oils, vegetable oils and essential oils.

* Read before the Sixty-eighth Annual Session Arkansas Medical Society, Little Rock, April 19, 1943.

(b) Dyes and dye intermediates.

(c) Certain explosive skin irritants, such as tetral and TNT.

(d) Rubber compounds, rubber accelerators, often irritate the skin of workers.

(e) Plants: Many plants and weeds irritate the skin of certain individuals. Gardeners and florists may suffer dermatitis from them. Among the most common plant and weed irritants are poison ivy, sumac, poison oak, pyrethrum, walnut, primrose and ragweed.

(f) Biologic agents: May be divided into three classes:

(1) Parasitic insects, such as may cause grain itch, straw itch and linseed itch.

(2). Bacterial infection, such as erysipeloid, caused by the bacillus of swine, erysipelas, occurring among butchers and carcass workers, anthrax among hide and wool handlers.

(3). Fungus infection, such as monilia infections, occurring on the hands of kitchen workers; ringworm infections, occurring among barbers; wool sorters, fur handlers, animal handlers and bath attendants.

The Workmens Compensation Law of Arkansas classifies dermatitis (4) as an inflammation of the skin due to oils, cutting compounds, lubricants, dust, liquids, fumes, greases or vapors. I think this will cover all cases of industrial dermatitis. The Commission is liberal in its interpretation.

Symptoms of occupational dermatoses:

In cases caused by concentrated irritants or by hypersensitiveness where the onset is sudden, there is first a sensation of itching and burning of the exposed parts. This is followed by erythema, papules, vesicles, edema, oozing and crusting. The eruption is an acute moist eczema.

A worker may develop symptoms from a few hours to a few days after contact with the substances. Cases have been reported where it has taken years for the patient to become sensitized. How often do we hear the expression: "Well, Doctor, I have been in this same work for weeks, months or years, and my occupation cannot be the cause."

Some workers develop a mild dermatitis and continue at work. In others the dermatitis is so severe they have to give up their work. This type seldom develops immunity. He may even become polysensitive. Substances like oils and greases do not only cause dermatitis, but if left on the skin long enough may cause comedones and acne, resulting in folliculitis and boils.

Occupational mycotic infections are not infrequent and do not differ from similar infections of non-industrial origin.

Guy Lane (5) believes that seven items are important in the history of an industrial dermatitis.

1. That the time relation between the exposure to the agent and the onset of the dermatoses is correct in a particular case.

2. That the individual has an occupation with a high cutaneous morbidity.

3. That he has been working in contact with an agent known to have produced similar changes in the skin.

4. That the site of onset of the skin disease coincides with the maximum exposure of trauma.

5. That some of his fellow workers with the same agents have similar manifestations.

6. That no possible exposure outside his occupation has been found to be an agent which causes similar lesions.

7. That if the diagnosis is dermatitis, the history of multiple attacks coming after exposure and re-exposure to an agent, followed by improvement and clearing after cessation of exposure, constitutes most convincing evidence that an occupational factor is the cause.

With a careful history taken, technique as outlined, one should make a complete physical examination of the patient. Even if the patient states he has only had the eruption on his hands, he should be stripped and an examination of the whole cutaneous surface should be made. Often one will be surprised what this will show.

After you have decided that you are dealing with an industrial dermatitis, a search should be made for the offending agent. If one is unable to find this agent, then patch testing should be resorted to. This should only be done when you are unable to find the agent by other means. This test should be done with the agent that the patient comes in contact with. He is instructed to bring a small amount of each material that he uses in his work for the patch test. A small piece of the suspected material is applied on a piece of undyed linen, or if a powder is tested, a small piece of moist linen is dipped in the powder or other material. This patch is placed on the unbroken skin. Usually the site for these tests are on the patient's back.

After the substance is put on the skin it is covered with cellophane or oiled silk, then these patches are covered with adhesive plaster. The patch should remain on for forty-eight hours. If a reaction occurs to any given substance used

in the test, provided that substance is not a primary irritant, then one can conclude that this substance is the cause of the existing dermatitis, unless there is a history of exposure to this substance and the reaction that develops resembles the present dermatitis. The diagnosis should be made of the offending agent by the type of dermatitis that is produced. It is usually an eczematous dermatitis resembling the present condition of the patient. One should also be careful to recognize the dermatitis that is often produced from the adhesive plaster.

Sulzberger (6) says that the demonstration of this specific allergic hypersensitiveness by means of the patch test may suggest, but does not necessarily prove, that the allergen is the cause of the presenting clinical dermatitis. For this reason the physician evaluating reactions should constantly bear in mind that a positive allergic response to a correctly performed patch test cannot possibly prove casual relationship, but can only demonstrate that there is an eczematous hypersensitivity of the particular skin site at the particular time and to the particular substance in the particular manner and concentration applied. Vice versa, an absence of reaction from the patch test performed demonstrates only that the particular skin site is not hypersensitive to the particular substance at the particular time and in the particular manner of exposure.

The absence of reaction may suggest, but not necessarily prove, that the allergen applied was not the cause of the presenting dermatitis. While it is generally admitted that patch tests when made properly are the most innocuous of all forms of skin tests, yet, states Sulzberger, there are grave consequences which may follow the improper use of patch tests and even the greatest care and conscientiousness are sometimes unable to prevent certain ill effects.

Plants: In testing for plants and weeds, the oleoresin is applied to the skin.

Finally, in many cases of industrial dermatitis, even after painstaking investigation and careful study, including patch testing, the question of whether the condition present is due to industrial exposure remains unanswered. The honest physician then has no alternative but to say: "I am not able to say whether or not the employee's occupation is the major factor in the production of this dermatitis."

Treatment: The treatment is dependent on the clinical state and appearance of the eruption. There is a dermatological axiom, "The angrier and more acute the dermatosis, the

milder must be the remedy." The moist lesions do better with wet dressings, such as boric acid solution 3% (saturated solution), aluminum subacetate 1/2 to 1% or potassium permanganate solution 1-5000. Later shake lotions should be used. Boric acid ointment is a safe ointment to use if there is too much drying by the lotions. Ichthyol 3% or liquor carbonic detergens may be added to the lotions or ointments. In subacute or chronic lesions the tars are indicated. In plant dermatitis the oral method of desensitization is used (7).

CASE REPORT

Patient R. M., female, aged 22, was employed at the glider plant. She worked in the wood parts with small pieces of wood which she glued together. About two weeks after she was on the job she noticed an itching and a papular eruption with vesicles and oozing on the flexor surface of her forearms. A patch test done with the glue that the patient used was positive in forty-eight hours. The patient continued to have recurrences when she returned to this work if her arms were not covered, but fortunately she has been able to resume this work.

Case No. 2: B. H., woman, aged 31, who is a window glazer. She has irritation between the fingers on the left hand, with swelling and a dermatitis in the palm of the hand. She handles putty and thought this caused the condition. She states if she has small cuts on her fingers from glass, she is more susceptible to the irritant. She has been working at present work five months. The putty is held tightly in her left hand which causes the putty to run between the fingers. In the right hand she has the putty knife, with which she spreads the putty. She noticed a slight irritation after two weeks at work. The condition would improve when she was off from work. There was edema (swelling) of the palm of the left hand with a papular-vesicular eruption between the fingers. Patch test to linseed oil was positive; patch test to the putty mixture negative. The putty dries very quickly. Putty used by glazers is a mixture of whiting (calcium carbonate) and linseed oil. However, this tends to dry up and fall apart unless lead is added. Hence, where a strong durable putty is required, white lead is added. Red lead or litharge is also added. Swartz states that in sensitive workers linseed oil is the usual irritant.

SUMMARY

Cause, prevention and treatment of industrial dermatoses has been discussed.

Case reports: Sensitivity to glue and linseed oil reported.

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MEDICAL AND HOSPITAL, OBSTETRIC AND PEDIATRIC CARE FOR WIVES AND INFANTS OF MEN IN MILITARY SERVICE

A. Descriptive Plan.

1. The Arkansas State Board of Health through its division of Maternal and Child Health will administer or supervise the administration of all services described in the plan.

2. The methods of administration approved under the 1943 Maternal and Child Health State Plan will apply to the administration of the "Emergency Maternity and Infant Care Funds."

3. Description of proposed services.

a. Procedures.

(1) Eligibility for Care Under the Plan.

All expectant mothers in Arkansas irrespective of legal residence, whose husband at the time of application is an enlisted man (including men deceased or missing in action) in the armed forces of the United States of the fourth, fifth, sixth, or seventh grade (Army, Navy, Marine Corps, or Coast Guard) and who makes application for such care, will be eligible for the medical and hospital maternity services provided under the plan, without cost to the family, when similar services are not otherwise available from the medical or hospital facilities of the Army or Navy or from facilities provided by or through official state or local health agencies. Even though his grade should change after the date of application the wife or infant would continue to be eligible for the maternity or infant care already authorized by the State Board of Health.

Any child under one year of age, whose father is an enlisted man as described in the previous paragraph, will be eligible for pediatric and other medical, surgical, and hospital care provided under the plan.

(2) Methods of Application for Care.

The form M suggested in the memorandum by the Children's Bureau of March 29, 1943, will be printed by the Division of Maternal and Child Health. This form will be distributed from state and local health, and Welfare agencies, army camps, hospitals, American Red Cross chapters, prenatal clinics, and other community agencies — official and nonofficial — and from local physicians participating in the program. The application form will be completed and

signed by the woman and by the attending physician (private or clinic physician) and be forwarded by the physician, or clinic to the State Director of the Division of Maternal and Child Health, or to a deputy authorized by him to receive such applications. The form will provide a place for entering the husband's service number. The serial number entered on the form shall be verified by the attending physician from the applicant's allowance card or a letter from her husband. In the exceptional case when this is not possible the Division of Maternal and Child Health will verify the husband's serial number through the Adjutant General's Office, War Department, Washington, D. C.; or the Bureau of Records, U. S. Navy, Room 3004 Arlington Annex, Arlington, Virginia; or the Commandant, U. S. Marine Corps, Washington, D. C.; or Commandant Headquarters, U. S. Coast Guard, Washington, D. C. Form M will be adopted as suggested in the memorandum by the Children's Bureau of March 29, 1943, for the application form for medical or hospital care for infants. A similar procedure for handling form M₁ will be used as for form M.

(3) Methods and Policies of Authorization for Payment of Services.

The State Director of Maternal and Child Health, or his duly authorized deputy shall promptly notify in writing the patient, the attending physician, or clinic, the local health department, and the hospital (if hospital care is recommended by the attending physician) as to whether or not the care applied for is authorized.

Medical care will not be authorized under this program when similar services are readily available from the medical personnel of the Army or Navy. At present this type of service is only available in the Camp Chaffee area at Fort Smith, Arkansas. Hospital care may be authorized in Army and Navy hospitals and paid for at the per diem rates for dependents of men in the armed forces usually charged by such hospitals. At present no such care is available in the state. When "similar services are otherwise available"; that is medical, nursing, and hospital care for wives and infants of servicemen of specified grades provided without cost to the family and without financial investigation, by a state or local health department, or under arrangement made through a health department with another agency, such programs of service should be continued and utilized in connection

with this program. At present no such services are available in this state.

• Authorization for maternity care will cover the services rendered at the visit when the request for authorization was signed by the physician but will not cover any previous care rendered.

Authorization for care of sick infants will be made retroactive to cover the care rendered during the first week of illness while authorization was pending, but will not cover any previous care rendered the infant. The initial authorization for medical care of sick infants will be limited to medical services the cost of which does not exceed \$20. Before additional authorization is granted the case will be reviewed by the State Director of Maternal and Child Health or by a pediatrician designated as a consultant by the State Board of Health.

Authorization for emergency consultation will be made retroactive.

Application for authorization for hospital care in case of emergency will be submitted by the hospital or attending physician within twenty-four hours of admission to a hospital, and these applications when authorized will be retroactive to cover the emergency period while authorization was pending.

Initial authorization for hospital maternity care will not be for more than fourteen days, and a minimum stay of ten days postpartum will be arranged if at all possible, in any acceptable hospital in the community. Initial authorization for pediatric hospital care will not be for more than fourteen days. Renewal of authorization for maternity or pediatric hospital care will be made only after review of the case by the Maternal and Child Health Director or a consultant designated by the State Board of Health.

Authorization for medical or hospital care will be made by the State Board of Health under agreement with the physician or the hospital that no payments will be accepted from the patient or family.

(4) Referrals for Medical Services.

Do not plan to refer patients to hospital outpatient departments. There is only one outpatient department in state, and it does not give services without financial investigation of patient. Health department clinics that have arrangements for assuring satisfactory care throughout pregnancy, labor and the postpartum

period will be utilized whenever arrangements can be made for acceptance of cases under the plan.

Infants included under this program will be referred to child health conferences for medical supervision and immunizations wherever arrangements can be made. Those with crippling conditions will be referred to the Crippled Children's Division of the State Welfare Department.

(5) Referral for Social Services.

Plans will be made to provide the services of a medical social worker for consideration of social needs and utilization of community resources in meeting them. Such services will be given by a medical social worker on the staff of Division of Maternal and Child Health.

The cooperation of state and local departments of welfare and other public or private agencies will be sought in meeting individual problems which interfere with medical care such as unsatisfactory living conditions, separation from husband and family, inadequate income, and lack of proper food. Fund A or B under the regular Maternal and Child Health program will be used for the employment of a medical social worker.

(6) Transfer of the Records of Patients Moving from One Locality to Another.

A notice will be placed at the bottom of the record, "authorization for medical and/or hospital service," sent to the patient requesting that we be notified in the event that she moves from her present locality to another locality in this state or to another state. The physician whom she selected to render medical service will be notified that the patient has moved from the locality and that he should submit to us immediately his bill for services rendered along with the physician's record of medical care. If the patient moves to another locality in this state she will be sent another application form which she will be expected to complete as well as the physician whom she chooses to render medical service in order that we may renew the authorization for medical and hospital service. The physician will be sent a copy of the physician's record of medical care sent into the office by the original physician. Should the patient move to another state, a copy of the physician's record of medical care will be sent to the Division of Maternal and Child Health of the state to which she moved.

(7) Payments for Medical Care.**(a) Maternity Care.**

Do not plan to purchase services in hospital out-patient departments or other clinics not maintained by official health agencies.

Payments to private physicians participating in the program will be made on a case basis rather than a fee-for-visit basis.

Payments will be made only for the service rendered **after** official authorization except for visits when authorization is pending or for emergency medical care.

\$35 will be paid to the attending physician by the State Board of Health upon receipt of evidence in the attached report form of complete medical service to the case as follows: At least five prenatal examinations, care of complications, obstetric operations, postpartum care, and postpartum examination approximately six weeks after delivery and routine blood tests for syphilis, hemoglobin determinations, and urinalyses. If prenatal care is provided in a clinic or by some other physician, the physician will be paid \$25 for his services during labor (at home or in approved hospital) and postpartum care and examination approximately six weeks after delivery. If the attending physician does not give prenatal care, he will receive \$25 for care during delivery and the postpartum.

As the need arises, fee schedules for non-obstetric surgery and other specialized consultant services required during pregnancy, labor, or within six weeks postpartum will be considered by the State Board of Health in conference with the technical advisory committee selected and approved by the State Board of Health. These fee schedules will be submitted to the Children's Bureau for approval.

(b) Medical Care for Sick Infants.

The amount of payment to a physician for the care of a **sick infant** will be calculated from the following maximum scale of payment in relation to the place and date of visits reported by the physician.

A. First visit during first year of infant's life—

If at home—\$4.00

If in office or hospital—\$2.00

B. All additional visits in first year of infant's life—

If at home—\$2.00

If in office or hospital—\$1.00

C. With maximum payment for first week of illness—\$10.00

D. With maximum payment for any subsequent week of illness—\$5.00

As the need arises, fee schedules for minor or major surgery for infants, or specialized consultant services or rates of payment for care of sick infant for period of longer than three weeks, will be considered by the State Board of Health in conference with a technical advisory committee selected and appointed by the State Board of Health. These fee schedules will be submitted to the Children's Bureau for approval.

(c) Payments will be made to the attending physicians or consultants by the State Board of Health on the basis of invoices accompanied by completed medical records, on forms prepared by the State Board of Health for this purpose after approval by the State Maternal and Child Health Director or his deputy.

When review of the Maternity or pediatric records submitted shows that the standards of care recommended have not been provided, further care by such physicians will not be authorized by the State Board of Health.

(d) Whenever a case load warrants it, as in some defense areas and near military concentrations, consideration will be given to the employment of full-time or part-time physicians on a salary basis and whether such employment will assure care of the best quality and the same time serve the interest of economy in the use of funds.

(e) The cost of establishing and maintaining prenatal and child health clinics where they are not already provided will be met from the regular Maternal and Child Health Funds A or B, if we can obtain physicians and nurses to carry on such program.

(10) Payments for Hospital Care.

The State Board of Health will purchase hospital care at the ward cost per patient day calculated in accordance with the method specified in the memorandum issued by the Children's Bureau of March 15, 1943.

These ward costs per patient day are to be inclusive of all operating costs for in-patient hospital care, including operating room, drugs and casts, laboratory, X-rays, anesthesia, physical therapy, and other services. The cost of

blood transfusions at the customary minimum rates of the hospital and exceptional costs may be provided for. The statement of operating expenses should exclude all expenditures for educational and religious purposes, research, the value of donated or volunteer services, outpatient services, replacement of equipment, depreciation of buildings or equipment, rent, interest, and other nonhospital operating expenses, such as gift shops, lunch counters, etc. Since the cost of interne and resident staff are included in the hospital ward cost per patient day, expenditures will not be approved under these plans for payment to internes or residents for medical services rendered.

Payment per patient day for ward care after 14 days hospitalization of any individual shall not exceed 75 per cent of the calculated ward cost per patient day, unless the average stay for the hospital is longer than 14 days, in which case the 25 per cent reduction in rate will apply for the period of hospitalization of an individual beyond the average length of stay for the hospital. In such cases these hospitals will be required to furnish as a part of their statement the calculation of the average length of stay.

A hospital that has been paid \$500 or more from Maternal and Child Health funds, Federal or matching, for hospital care during the last fiscal year or during the current fiscal year will provide the State Board of Health with a statement of its operating expenses and calculation of ward costs per patient day for its most recent accounting year. This statement must be certified by a competent public accountant. It will be understood that certification by a **certified** public accountant is not required. Certification by any competent public accountant who is not an employee of the hospital will be acceptable.

Hospitals paid less than \$500 of Maternal and Child Health funds, Federal or matching during a year for hospital care may submit statements of operating expenses and calculations of ward costs per patient day as described above or will accept payments from these funds on the basis of a uniform inclusive ward rate of \$4.00 per day.

If the certified statements received from some of the hospitals appear to establish excessive ward cost per patient day as compared with ward cost per patient day for services of comparable quality in other hospitals in the state, the State Board of Health may wish to establish

a maximum ward rate to be paid under the program.

Payments will be made to the hospital upon receipt of invoices accompanied by information showing the date of admission and discharge of each patient for whom care was officially authorized and a statement that the hospital had not charged nor received payment from the patient or family for any of the services rendered.

Payments will be made for the day of admission of the patient but not for the day of discharge.

B. Standards.

(1) Medical Services.

Do not plan to purchase services for prenatal and postpartum and for Child Health Conferences.

Medical care provided under the plan may be authorized when the attending physician or consultant is a graduate of a medical school approved (at time of graduation or subsequent to graduation) by the Council on Medical Education and Hospitals of the American Medical Association, and is licensed to practice in the State of Arkansas. For the period of this emergency program individual exceptions will be made. First, when a person with the degree of Doctor of Medicine and licensed to practice in the State of Arkansas, who is not a graduate of a medical school approved (at time of graduation or subsequent to graduation) by the Council on Medical Education and Hospitals of the American Medical Association, and second, when a person who is not a graduate of a medical school but is licensed to practice medicine in the State of Arkansas, and has been practicing medicine for thirty years has completed postgraduate training in obstetrics and/or pediatrics which, in the opinion of the State Health Officer and his Technical Advisory Committee, makes him competent to participate in this program.

Specialists who are certified by their respective American Boards or whose training and experience meet the requirements of such boards will be designated as consultants by the State Board of Health and whenever possible made available for consultation with general practitioners participating in the plan. Physicians who have had not less than one year of graduate training in obstetrics or pediatrics and at least one year's experience in the specialty will be designated as assistant consultants. Consultants

and assistant consultants in obstetrics and pediatrics will be paid a fee of \$10.00 when consultation is necessary.

For areas where consultants with the training and experience as set forth in the above paragraph are not available, a technical advisory committee selected and approved by the State Health Agency for this program may designate for each such area of the State a physician who is generally recognized as a particularly competent physician or physicians in the practice of obstetrics, pediatrics, or other specialty to serve as a consultant in his special field. Lists of consultants approved for various specialties will be made available to all physicians participating in the program.

Physicians not qualified as consultants or assistant consultants will be advised to obtain the consultation services provided under the plan (when available) prior to undertaking any serious complications of pregnancy or for the treatment of a serious illness of all infants except in the rare instances when an emergency does not permit him time for calling consultation.

(2) Hospital Services.

Hospital care or medical care in a hospital will be authorized only in hospitals that have been approved by the American College of Surgeons or which after inspection have been approved by the State Board of Health as meeting the standards of obstetric and pediatric services established by the State Board of Health as outlined by the Children's Bureau.

Whenever there is a choice of hospitals those that employ interne and resident staff and meet the standards for institutions approved for internships or residences will be selected. Likewise hospitals having an obstetrician and a pediatrician, certified or otherwise fully qualified, on the attending staff are to be preferred over those which do not.

The state is divided into four consultant nursing districts. The consultant nurse in the district will be expected to make inspection of the hospitals in her area. It will be our plan to have these hospitals rechecked at least annually.

WHOSE DEPENDENTS ARE ELIGIBLE UNDER THIS PLAN—RANKS OR RATINGS OF ENLISTED MEN (As of April 23, 1943)

ARMY—Private; Private, first class; Corporal; Technician, 5th grade; Technician, 4th grade; Sergeant.

NAVY—Aerographer's mate, third class; Aviation electrician's mate, third class; Aviation machinist's mate, third

class; Aviation metalsmith, third class; Aviation ordnance man, third class; Aviation radioman, third class; Baker, third class; Boatswain's mate (cox); Bugler, first class; Bugler, second class; Carpenter's mate, third class; Cook, third class; Electrician's mate, third class; Fire controlman, third class; Fireman, first class; Fireman, second class; Fireman, third class; Gunner's mate, third class; Hospital apprentice, first class; Hospital apprentice, second class; Musician, second class; Painter, third class; Parachute rigger, third class; Pharmacist's mate, third class; Photographer's mate, third class; Printer, third class; Quartermaster, third class; Radarman, third class; Radioman, third class; Radio technician, third class; Seaman, first class; Seaman, second class; Seaman apprentice; Ship's cook, third class; Shipfitter, third class; Signalman, third class; Soundman, third class; Specialist, third class; Steward, third class; Steward's mate, first class; Steward's mate, second class; Steward's mate, third class; Storekeeper, third class; Telegrapher, third class; Torpedoman's mate, third class; Yeoman, third class.

MARINE CORPS—Private; Private, first class; Corporal; Assistant cook; Field cook; Cook, third class; Chief cook; Field music; Field music, first class; Field music corporal; Field music sergeant; Steward's assistant, first class; Steward's assistant, second class; Steward's assistant, third class; Steward, third class; Mess sergeant; Sergeant.

COAST GUARD—Aviation machinist's mate, third class; Aviation metalsmith, third class; Bugler, first class; Carpenter's mate, third class; Coxswain; Electrician's mate, third class; Fireman, first class; Fireman, second class; Fireman, third class; Gunner's mate, third class; Mess attendant, first class; Mess attendant, second class; Mess attendant, third class; Musician, second class; Officer's steward, third class; Parachute rigger, third class; Pharmacist's mate, third class; Photographer's mate, third class; Printer, third class; Quartermaster, third class; Radarman, third class; Radio technician, third class; Radioman, third class; Seaman, first class; Seaman, second class; Seaman apprentice; Signalman, third class; Ship's cook, third class; Soundman, third class; Specialist, third class; Storekeeper, third class; Yeoman, third class.

WHAT ARE YOU DOING ABOUT IT?

Q. "What do you think freedom from want means?"

A. "Freedom from want means—that you shall have medical care as needed, by some method which your Government may agree on."
—Eleanor Roosevelt, Ladies Home Journal, June, 1943, p. 30.

CHANGE IN CASEC MEASUREMENTS

Casac now measures six **packed** level tablespoonfuls instead of 12 level tablespoonfuls, as formerly, so that directions to the patient should be amended accordingly. Casac is indicated in colic and loose stools in breast-fed infants, and in fermentative diarrhea, malnutrition, celiac disease and for premature infants. Mead Johnson & Company, Evansville, Indiana, U. S. A.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

THE FIRST STEP in the rehabilitation of a tuberculous person is physical restoration, which is particularly the province of the physician. In the further adjustment of the inactive patient the lay worker who attempts to serve the patient without learning the story of diagnosis, treatment and recovery from the physician, treads on quicksand. Most successful rehabilitation follows the concerted application of the medical skill of the physician and the special information and training of qualified lay workers. Practical suggestions for the family physician who is interested in such coordination are here presented by Dr. F. L. Jennings.

THE FAMILY DOCTOR, THE PATIENT AND THE JOB

The private physician who has guided his patient through recovery from pulmonary tuberculosis is now being asked frequently to advise concerning some job which that patient may attempt without too great hazard. In this general manpower shortage, the patient with inactive tuberculosis, whether from civilian life, from induction centers, or discharged from military services, can find employment readily in many localities, particularly if he has an established skill. Beside that economic need which makes many patients reluctant to continue treatment for the prescribed period, patients now are moved by the wish to become a part of the war effort and sometimes by high wages. Some employers who hire all comers are unlikely to establish any safeguards for handicapped workers.

One of the physician's paramount difficulties has been the item of sufficiently definite information about the job in question. Jobs are changing rapidly. The exhausting task of a year ago has been reduced to machine-tending. Redesign, retooling, reorganization, re-routing, continue to make more specifications obsolete. Keeping up with such rapid and drastic change is impossible alike for any physician or lay worker without current sources of industrial information. Some physicians have sought to bridge this difficulty by such general terms as "light work," hoping thereby to protect the patient from excessive exertion, strain and tension. Unfortunately, employers' requirements are definite. Employment placement interviewers must meet these definite

requirements. A patient's ability to do "light work" is indefinite and unsaleable.

But there are now official and unofficial sources of information through which physician and patient may usually find definite indications concerning which job is free from undesirable hazards. The official services include the United States Employment Service, which has branch offices in most population centers, and the State Vocational Rehabilitation Services. The United States Employment Service has the most complete and currently accurate information on what jobs there are in each community and on what physical performance is required in each job. It has originated a "Physical Demands Form," which is being used experimentally to determine required physical activity and working conditions. This type of job analysis explores especially such items as continuous standing, sitting, lifting, stooping, etc. One purpose of this information is to check the specific requirements of the job against the specific limitations of the handicapped applicant.

Interested physicians may obtain copies of interim physical requirement forms from the National Tuberculosis Association. The larger offices of the U.S.E.S. also include executives or interviewers who have some experience in special placements and who are qualified to discuss the subject of suitable placement for recovered patients with their physicians. The U.S.E.S. has placed thousands of inactive tuberculous patients in hundreds of different jobs. The suitability of these placements has depended most

of the time on the quality and quantity of medical information available.

When the recovered tuberculous patient has no marketable skill, or when his old job is contraindicated medically, application for training or retraining and placement should be made to the State Bureau of Vocational Rehabilitation. Financed by State appropriations and Federal matching funds, these Bureaus are empowered to impart specific vocational training and placement to handicapped adults in order to make them self-supporting.

The physician will find in Federal Form R-3a (revised), published by the Federal Vocational Rehabilitation Bureau and in the manual prepared for its interpretation (Misc. 2328) practical bases upon which rehabilitation agent and physician may cohere their services for the patient.* The form and the manual are the result of many consultations between Federal rehabilitation personnel and members of the Council of the American Trudeau Society and other phthisiologists of long experience. Many state agents and supervisors have learned that, as the Federal manual points out, direct interview between physician and rehabilitation worker is the most satisfactory procedure for both.

A number of the state and local tuberculosis associations have included rehabilitation in their program objectives. Some have employed special personnel competent to assist the patient in finding his way to appropriate training or placement or both. Rehabilitation workers employed by voluntary agencies are well aware that the patients of private physicians may have as much need for their services as the sanatorium graduate. The physician may find it well worth while to inquire from the nearest tuberculosis association, what it has to offer in the direction of rehabilitation.

Both official and voluntary resources have been stimulated and encouraged by changing attitudes within industry. Not manpower shortage alone, but a cumulation of satisfactory performance by former patients, has done much to improve this situation.

The nation's leading personnel agency, the United States Civil Service Commission, has conducted surveys of jobs in several types of Federal services and in war-contract industries in search of jobs suitable for physically handicapped persons. Prospective employment for

persons with a history of tuberculosis has been conspicuously included.

This precedent has been matched by action on the part of the National Association of Manufacturers. In the December, 1942, supplement of its Industrial Relations Bulletin, the N. A. M. indicated that various handicapped groups are a new labor source. Specific mention is made of employees who have suffered amputations, deafness, blindness, organic heart diseases and tuberculosis. For each group, a partial list of suggested jobs is offered. The bulletin indicates that one of the parallel practices in employing handicapped workers calls for "careful selectivity in applying the handicapped man to a job which he can do." Again the private physician and the industrial doctor are able to provide medical advice and counsel. A number of large employers have recently utilized the specific job-analysis method developed by the United States Employment Service, described above.

Tuberculosis literature is not without its contributions on rehabilitation information of value to the physician. The American Review of Tuberculosis has in preparation articles prepared by the United States Employment Service, and the Federal Vocational Rehabilitation Bureau regarding their procedures in cases eligible for their services. The Rehabilitation Service of the National Tuberculosis Association is preparing special releases on the subject of patients not eligible for official services. Thus, the physician, when called upon to advise his patient occupationally, may utilize the services and the publications of the United States Employment Service, the Rehabilitation Bureaus and the tuberculosis associations to good advantage.

Written especially for Tuberculosis Abstracts, by F. L. Jennings, M. D., Supt. and Med. Dir., Sunnyside Sanatorium, Indianapolis, Ind.

**If You Can't Carry A Gun
Shoulder The Cost Of One
BUY WAR BONDS.**

* Available from the Vocational Rehabilitation Bureau, Federal Security Agency, Washington, D. C., or through tuberculosis associations.

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EDITORIALS

THE 1943 ANNUAL SESSION OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION

The annual session of the American Medical Association for 1943 was restricted to meetings of the House of Delegates, all scientific programs being abandoned. 171 of 175 delegates were present, attesting to the interest which the component societies have in the national organization.

The proceedings were dominated by consideration given to the problems of public health and the practice of medicine as are affected by the war and as they may be affected in the postwar world. From a number of resolutions, the House provided for the creation of a Council on Medical Services and Public Relations whose

functions shall be (1) to make available facts, data and medical opinions with respect to timely and adequate rendition of medical care to the American people, (2) to inform the constituent associations of proposed changes affecting medical care in the nation, (3) to inform constituent associations of the activities of the Council, (4) to investigate matters pertaining to the economic, social and similar aspects of medical care for the people, (5) to study and suggest means for the distribution of medical services to the public consistent with the principles adopted by the House of Delegates, and (6) to develop and assist committees on medical service and public relations within the constituent associations.

A Committee on the Planning of Postwar Medical Service was also created. Exhaustive reports were presented on the relations between physicians and hospital prepayment plans, especially in connection with roentgenology. The House approved the present plan for the provision of obstetric and pediatric services to the dependents of enlisted men with the modification that cash allotments be made to wives in need of such assistance rather than by stipulation of fee and payment direct to the physician. The House also (1) approved the Red Cross First Aid Manual, (2) adopted essentials for acceptable schools for clinical laboratory technicians and for physical therapy technicians, (3) approved the teaching of biology in high schools, (4) approved a program of postgraduate work for physicians in the armed forces and civilians, and (5) reapportioned delegates, the representation from Arkansas being unchanged. There were 122,741 members of the American Medical Association on April 1, 1943, an increase of 2,040 over the April 1, 1942, membership.

The Distinguished Service Medal was conferred upon Elliott P. Joslin, Boston, famous as a contributor to present-day knowledge of diabetes. At the closing session, Herman L. Kretschmer, Chicago, was elected President; John J. Amesse, Denver, was elected Vice-President; Olin West, Secretary, and the following were elected members of the Board of Trustees: Ernest E. Irons, Chicago, and William F. Braasch, Rochester, Minnesota. War conditions permitting, the 1944 annual session will be held in Saint Louis; the 1945 session in New York, and the 1946 session in San Francisco.

MEDICAL AND HOSPITAL CARE OF WIVES AND INFANTS OF ENLISTED MEN

This issue contains the plan for medical and hospital care for wives and infants of enlisted men as finally accepted by the Children's Bureau, Washington. The original plan has been revised at the suggestion of the Committee on Maternal and Child Welfare of the Society in regard to the eligibility of physicians to participate in the program. It is now felt that there may be a more general participation by Arkansas physicians in the plan and that such professional services may be generally available over the state to the beneficiaries. The Journal suggests that those physicians whose qualifications are to be reviewed by the state health officer and his technical advisory committee should now make formal application to the state health officer for approval.

PROCEEDINGS OF SOCIETIES

The Union County Medical Society met at the Warner Brown Hospital, El Dorado, July 7th, for the following program: "Experiences as a Defense Plant Physician and Surgeon," Wm. A. Snodgrass, Jr. The Society voted its disapproval of S. B. 1161 (Wagner-Murray bill). The following officers have been elected: President, D. E. White; Vice-President, P. H. Muse, and Secretary-Treasurer, M. V. Russell.

M. V. Russell, Secretary.

The annual picnic session of the Benton-Washington County Medical Societies was held at Siloam Springs July 8th. Following the picnic dinner, the following program was presented: "University of Arkansas School of Medicine," Byron L. Robinson; "Caudal Anesthesia," Jeff Banks; "Typhus and Rocky Mountain Spotted Fever," Chas. H. Winkler, and "Neurosurgical Considerations," Robert Watson, all speakers of Little Rock.

Geo. M. Love, Secretary.

The Craighead-Poinsett County Medical Society met July 1st in luncheon session for several talks on general topics and for motion pictures on "Vitamin B₁." The Society will next meet in Cash.

J. H. McCurry, Secretary.

PERSONALS AND NEWS ITEMS

B. L. Bailey has moved from Star City to Sterlington, Louisiana.

L. H. McDaniel has been elected membership chairman of the American Legion Post at Tyronza.

Carroll F. Shukers, Little Rock, now stationed overseas, has been promoted to major.

Lt. Burch V. Raley, Little Rock, is now stationed overseas.

Capt. Doyle W. Fulmer, Little Rock, is now stationed overseas.

A. D. Cathey has been elected surgeon of the El Dorado Post of the American Legion.

E. J. Horner has been elected surgeon of the Jonesboro Post of the American Legion.

W. E. Gray, Hot Springs National Park, has passed examination as a diplomate of the American Board of Radiology.

Clyde McNeil has been elected surgeon of the Rogers Post of the American Legion.

B. H. Hawkins has been elected surgeon of the Mena Post of the American Legion.

MARRIED—On June 22nd, B. L. Moore and Miss Mary Athelene West, at El Dorado.

"Roentgen Ray Therapy of Paranasal Sinuses" by Fred Hames, Pine Bluff, appeared in the July issue of the Southern Medical Journal.

Vincent O. Lesh, Fayetteville, has been promoted to Major, Medical Corps, Army of the United States, and assigned to the 259th Station Hospital, Camp Adair, Oregon.

Lt. Max Baldrige, Conway, is on duty with a naval destroyer force.

Alan A. Gilbert, Fayetteville, has been re-elected Chairman of the Washington County Chapter, American Red Cross, for the fifth consecutive term.



Such language!

My boss used to be as grumpy as a bear. He'd growl and bang around and his wife said: "Poor George, he's working too hard. It's wearing him down to a frazzle!"

So, I told her a few plain facts:

... how I'd discovered the most amazing thing ... that physicians who prescribe S-M-A* actually have more time for other things ... because it isn't necessary to change the formula throughout the entire feeding period. (She sat up at that.)

... how S-M-A eliminates many unnecessary questions that mothers usually ask about other modified milk formulas.



When I had finished, she said she would certainly speak to George about using S-M-A as a routine formula.

★ ★ ★

Just because my boss turned over a new leaf ... he wants everybody to pat him on the back for it. But he's not fooling us ... we know how he got to be such a nice man.

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tion of milk sugar and potassium chloride; altogether forming an antirachitic food. When diluted according to directions, it is essentially similar to human milk in percentages of protein, fat, carbohydrate and ash, in chemical constants of the fat and physical properties.

RANDOM THOUGHTS OF THE SECRETARY

June 23rd. Again in conference in Conway, now known as the "City of Physicians."

June 25th. During daylight hours, of all times, comes another of Bob Robins collect phone calls, this one from New York where he is meeting the great and near-great after an interval in Washington.

July 4th. Passing the quietest of Independence Days, to which the youngster's absence at camp is assigned much of the freedom from noise. Comes Alan Gilbert on a week's assignment to active duty at Camp Chaffee, another novelty in this unusual army of 1943, and Alan properly wonders at the final answer.

July 8th. Finally comes notice that the Society is exempted from Federal income tax, thus happily ending our efforts for the past year on this problem.

July 9th. Talley, the heckling representative of one of our valued advertisers, comments sarcastically today on the column of last month as given over to a recital of the woes over the loss of a part of a finger. Well jeers he at the scar who has never felt the wound, etc.

July 12th. Personal to Clyde McNeil, W. J. Schwarz, and members in the Ninth Councilor District—we almost sold an alarm clock today.

July 14th. Indirectly learning that Jim Amis has had chicken livers at his location in the Pacific, we are happy to know that the Navy has finally come to the realization of what our comrade mostly desires.

July 17th. Much in the manner of former years, heading for Colorado tonight and some one else will have to worry over procurement and assignment for these next ten days.

BOOK REVIEWS

A Manual of Clinical Therapeutics: By Windsor C. Cutting, M. D., Associate Professor of Therapeutics, Stanford University School of Medicine, San Francisco, Calif. 609 pages. Philadelphia and London: W. B. Saunders Company, 1943. Price \$4.00.

This volume is compact, briefly presenting therapeutic procedures, yet with sufficient detail as to make it of practical day by day help.

Chemotherapy of Gonococcal Infections: By Russell D. Herrold, B. S., M. D., Associate Professor of Surgery (Urology), College of Medicine, University of Illinois. 137 pages. Saint Louis: C. V. Mosby Company, 1943. Price \$3.00.

The author discusses the latest developments in the treatment of gonococcal infection, giving methods which proved successful in the majority of cases together with those employed in the more difficult cases. Study of this volume should enable the practitioner to more effectively treat these diseases.

OBITUARY

TILDEN PAUL FOWLER, age 66, Harrison, died unexpectedly while on a professional call July 5th. Born in Boone county, he had practiced there since 1903. Surviving him are his son, Ross Fowler, associated with him in practice at Harrison, one other son and four daughters.

COMMUNIQUE

B. A. Bennett, O-255345,
Major, M. C., 42 Gen. Hosp.,
A. P. O. 923, U. S. Army,
San Francisco, Cal.,
May 29, 1943.

To the Editor:

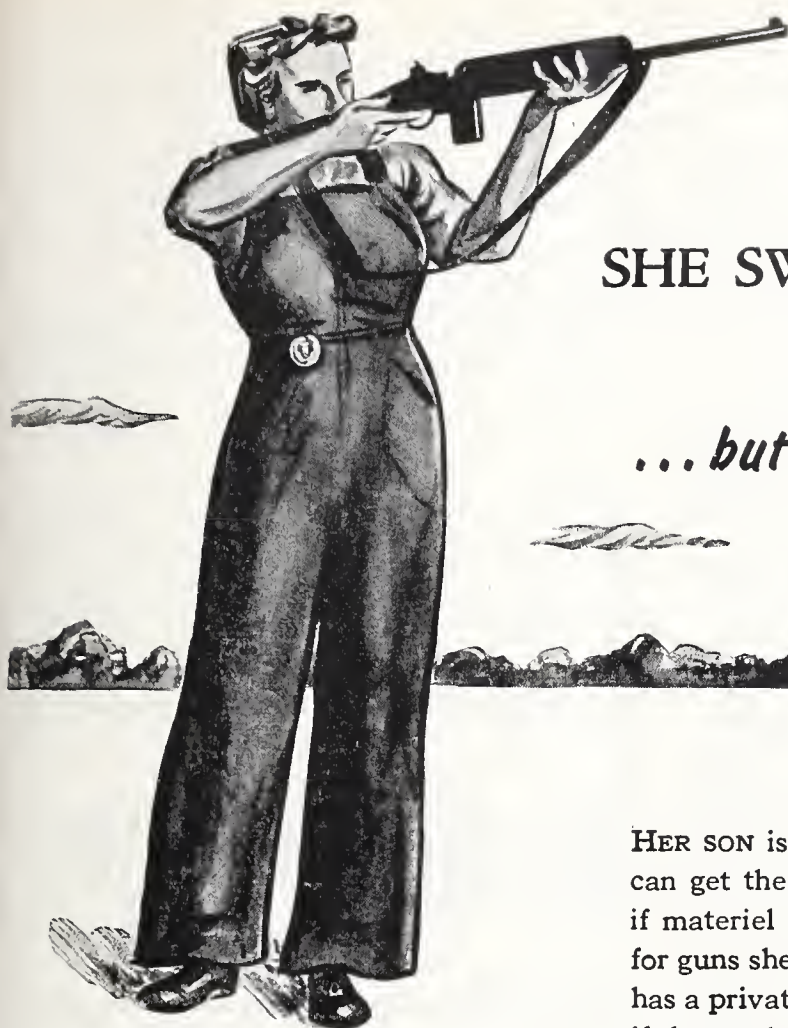
Thanks a lot for the program of the State Meeting. I am sure that you all enjoyed the whole thing and I know of a lot more of us that would have enjoyed it with you.

Excuse the oversight in spacing as we are getting short of paper in these parts.

The two Journals that have arrived came in last week for March and April, and I want you to save some of the steaks that you write about for a date in the near future, I hope. That is a lot different to bully beef and dehydrated turnips and there are times when they are gladly considered delicacies in some parts of this area.

Say, young fellow, there is a lot of difference in an old bird getting older, and one getting mixed up with a supply track. You know the supplies have to get through at any cost in this vicinity. The only trouble that I am having with crippled elevator is the heavy cast that I have to help along. I am in a hospital staffed by a swell bunch of men from Baltimore and they are really doing a good job. Our nurses over here come in for their share too as they are really the cream of the crop. They have had to overcome obstacles that they had never dreamed of before but they have come through with their chins up and still looking straight ahead.

I have seen several of our boys from our school there in different parts over here. They are scattered all the way from the extreme southern tip to forward posts in N. G., and they are all making a fine record for themselves.



SHE SWAPPED GLAMOUR FOR GUNS

... but she's still a woman

HER SON is in the infantry—and she knows that he can get the “job” done quicker and be home sooner if materiel is not lacking. Hence, swapping glamour for guns she takes her place in the war effort. But she has a private fight. She’s at the age when she wonders if she can keep fit—physically as well as emotionally.

Clinical records show that today loss of time because of menopausal distress is largely unnecessary. Such symptoms can be relieved by adequate therapy with natural or synthetic estrogens.

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They have all been practicing in other states since they left school and the only one you most likely remember is John Smith (W. F.). I have not seen him for several months but he was really making tracks at that time. Another one from L. R., Ray Fulmer (Cy's nephew) is in a Station Hospital across town from this one and he, too, is making a fine record.

I heard this one at one of the hospitals on my last trip to N. G. A good Alabama Negro boy told the nurse that morning that he had a dream the night before. He said the Nips had been over him and hit him with a big bomb. He took right off and when he got to the Pearly Gates he asked for permission to come in. St. Peter wanted to know where he was from, what he had been doing and where he lived, etc., and then told him to "Go on back to the dock and get to work, yore time jus' ain't come yet." We did not think much of them when we left home but those that are in labor groups are doing a nice job all round this theater.

What is your reaction to the boy from New Orleans on the new order for medicine in the future? It seems to me from this view here, we

older fellows will be in a hell of a fix when we do finally get home. All the younger men will have to stay in whether they want to or not, to take care of all these outposts and clean out the hospitals at home that will be filled with malaria for the first ten years.

Thanks again for the program and your letter.

Best regards to you all, wherever you are.

Sincerely,

Bennett.

Maj. Byron A. Bennett, who has been stationed in the South Pacific for sixteen months, sustained a fracture of a leg about three months ago and recently visited at his home in Little Rock.

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No. 4

ANALYSIS OF THYROID SURGERY *

J. HARRY HAYES, M. D.
Little Rock

It is the purpose of this paper to unfold the status of thyroid surgery in hospitals of Little Rock, Arkansas. To do this the last 437 cases up to January 1, 1943, were reviewed. Cases were taken from three institutions, and an earnest attempt is made herein to bring out as many facts as possible so that the results and trends of thyroid surgery in this locality may in a general way be compared with results and trends elsewhere.

In 437 cases where operations were performed, there were 32 operators, three of whom had a sufficient number of cases for them to be considered separately. For the sake of convenience the cases of the other 29 are grouped together.

TABLE No. 1

TOTAL NUMBER THYROID OPERATIONS 437
TOTAL NUMBER OF OPERATORS 32
OPERATORS

No. 1	Number of cases	168	Mortality	0%
No. 2	Number of cases	61	Mortality	4.91%
No. 3	Number of cases	55	Mortality	5.45%
No. 4 (29)	Number of cases	153	Mortality	5.81%
AVERAGE MORTALITY 4.42%				

Table No. 1 shows the number of cases by each operator and the mortality rate. This table indicates, as most other analyses will show, that as a general rule where a large number of operators are taken into consideration the mortality rate will be higher than for individual operators who frequently do thyroid surgery.

The average mortality rate of these 437 cases was 4.42%. This, no doubt, could be classed as good, considering the fact that three institutions with 32 different operators were considered: Mortality rates of large clinics run anywhere from a little above 0% in large numbers of cases to 5% and above. It has been said that, when death follows a thyroidectomy, too much surgery was done. This statement has a good foundation. It

has also been stated that, whenever the mortality rate is higher than .1% it's time to investigate.

These statements serve to emphasize that, following every death from thyroidectomy, a definite cause can be determined, and frequently the cause is one that could be eliminated if it were possible to handle case again. This is true of almost every case that results in death.

TABLE No. 2

CASES BY INSTITUTIONS

INSTITUTION No. 1	284 cases	mortality	2.46%
INSTITUTION No. 2	52 cases	mortality	3.84%
INSTITUTION No. 3	101 cases	mortality	5.94%
AVERAGE MORTALITY 4.8%			

Institution No. 1, having 284 cases, had a mortality rate of 2.46%. Of these cases nearly all were handled in a private manner. Institution No. 2 with 52 cases showed a mortality rate of 3.84%. Nearly all of these cases were handled in a private manner. Institution No. 3 with 101 cases and a mortality rate of 5.94% represents cases mostly handled in wards and by a variety of operators.

Table No. 2 clearly shows what is well known: that a general ward is no place for a thyrotoxic patient to be prepared for surgery or treated post-operatively. This institution had the highest mortality rate in spite of the fact that the institution took more than three times as long on the average to prepare the cases for operation. (Table No. 4.)

TABLE No. 3

CAUSES OF DEATH

INSTITUTION No. 1	284 CASES
Number of deaths:	7 or 2.46%
Thyroid heart disease	2
Hypostatic congestion	1
Liver deaths	3
Acute post-operative hyperthyroidism	1
INSTITUTION No. 2	52 CASES
Number of deaths:	2 or 3.84%
Thyroid heart disease	1
Thyrotoxicosis	1

* Read before the Sixty-eighth Annual Session, Arkansas Medical Society, Little Rock, April 19, 1943.

INSTITUTION No. 3	101 CASES
Number of deaths:	6 or 5.94%
Malignancy with metastases to lungs	1
Embolism	1
Diabetes and secondary anemia	1
Thyroid crisis	2
Cause undetermined	1

Table No. 3 lists the causes of death in each institution. These are as reflected in the records. In institution No. 1 it appears that six of the seven deaths probably occurred from the same cause, namely thyroid crisis. Some men consider liver death and death from post-operative hyperthyroidism as being the same thing. Evidently in institution No. 2 both deaths were caused from thyroid crisis. Institution No. 3 has a more extensive assortment of causes of death—as shown in Table No. 3. Of a total of 15 deaths nine obviously were due to thyroid crisis. This brings up the question of what is a thyroid crisis? To the vast majority a thyroid crisis means hyperaccentuated thyrotoxicosis. The exact etiology is unknown.

In the literature one is impressed with the thought that thyroid crises are seen more often previous to surgery than following surgery. Thyroid crisis is the reason so much care is given to patients prior to surgery. All other complications, in a general sense, would be classed as accidents. None of the other complications are prepared against pre-operatively as is thyroid crisis. If a patient is adequately prepared and there are no accidents at the time of operation, and excellent post-operative care is provided, thyroid crisis seldom occurs. Nevertheless, thyroid crisis is the outstanding cause of death following thyroid surgery. Hypostatic congestion was shown as the cause of one death. As a usual thing when fever persists following thyroidectomy after the post-operative reaction should have subsided, pneumonia is the cause.

Embolism is reported as a cause of one death. This would be classified as an accident, and it occurs less frequently than one might think since there is so much vascularity involved.

Causes of three other deaths were:

1. Malignancy with metastases to lungs.
2. Diabetes and secondary anemia.
3. Cause undetermined.

These three causes of death are, no doubt, open to question.

TABLE No. 4		
AVERAGE DAYS IN HOSPITAL		
	Pre-op. days	Post-op. days
INSTITUTION No. 1	4	8
INSTITUTION No. 2	5	8
INSTITUTION No. 3	15	10
Average	8 days	8 2/3 days

Institutions Nos. 1 and 2 had an average of eight post-operative days. Institution three had an average of 10 days. This in all probability is comparable with practice in other localities.

Institution No. 1 had an average of four pre-operative days with the lowest mortality; institution 2 had an average of five pre-operative days with a higher mortality, and institution 3 had an average of 15 pre-operative days with the highest mortality. This is the exact reverse of what should have been the actual results under average conditions. Of course, in addition to pre-operative preparations, innumerable other factors have a bearing on the mortality rate.

This brings up the question of when a thyrotoxic patient is ready for surgery. Requirements may be summarized as:

1. A lowered and/or favorable pulse rate.
2. An increase in weight or, at least, a stationary weight.
3. Lessened nervousness.
4. An improved and satisfactory aponea test.
5. A lowered and favorable Basal Metabolic rate.
6. Good morale.

The length of time required to produce these six requirements is of no importance in itself. The essential thing is to produce each and every one of them.

TABLE No. 5		
SEX OF PATIENTS		
	Males	Females
INSTITUTION No. 1	30	253
INSTITUTION No. 2	6	46
INSTITUTION No. 3	24	77
	60	376

Ratio of 1 to 6 4/15

Table No. 5 shows a ratio of one male patient to 6 4/15 female. The general average is about one male to eight females.

Table No. 6	
AGES OF PATIENTS	
Ranges from 17 to 69 years	
Average 35 years	
Duration of known existence three weeks to 40 years.	
Weight of Glands	
Largest	500 grams
Smallest	1 gram

Table No. 6 shows patient's ages ranging from 17 to 68 years with an average of 35 years.

The duration of the known existence of the goitres ranged from three weeks to 40 years. It might be said here that, in the opinion of the author, the patient is usually born with the tendency for goitre and the presence usually dates back to puberty.

The weight of the largest gland was 500 grams. It was relatively nontoxic. The weight of the smallest piece of tissue was 1 gram. Both were among the author's cases. That of the 1 gram tissue had been subjected to surgery twice before and had a relatively high basal metabolic rate with definite thyrotoxic heart disease. The removal of the one gram brought the basal readings within normal range and the heart disease promptly cleared up.

TABLE No. 7

TOTAL AND SUBTOTAL THYROIDECTOMIES

	Totals	Subtotals
INSTITUTION No. 1	113	171
INSTITUTION No. 2	17	35
INSTITUTION No. 3	30	71
	160	277

Table No. 7 gives the number of total and subtotal thyroidectomies reported. It will be readily apparent that total thyroidectomy is accepted in this locality to some extent. Of 437 goitres done, 160 were classified as totals. It might be added that the percentage of total thyroidectomies in this locality is on the rapid increase. Some take the position that if a portion of the thyroid gland is not left at operation hypothyroidism must follow. Others insist that from actual experience it does not follow. The author has had no embarrassing incidences following total thyroidectomy. It must be remembered that some patients need both thyroid extract and a thyroidectomy at the time of operation. In other words, symptoms of both hypothyroidism and hyperthyroidism can be, and often are, present in the same individual at the same time. Hertzler and Crotti both have excellent explanations in their respective books on the thyroid.

It has been said that total thyroidectomy should not be encouraged because too many complications would ensue if every one were doing totals. Here, it might be pointed out that cholecystostomy is easier to do than a cholecystectomy. The comparison is the same.

If the gland is hyperplastic, it should be removed in its entirety since the entire gland is involved. If any portion of the gland is left, the patient has to put up with that much of the

disease, even though he may be relieved of a large part of his burden. The avenue to recurrence is wide open, and too often he is in the middle of the road of a persistence.

In the nodular goitre, it must be remembered that the nodules must have a beginning. The patient assuredly has the tendency, and who can be sure in the absence of inspection that the lobe of the opposite side does not contain a nodule? Too often it does, and those nodules are the seat of malignant changes. The author would not quibble over the removal or leaving behind of a small fragment of tissue in a gland that is not friable and toxic to the detriment of the patient's immediate well being, but the rule should be to worry about how much is left in and not worry about how much was taken out. As long as only thyroid tissue was removed, all is well if enough was removed. We must remember that the young use this gland to grow up on but the matured do well without any part of their goitre. Removal of the entire normal gland is an entirely different subject.

TABLE No. 8

Institution No. 1	284 Cases
Number of patients having previous operations	13
Number of ligations	6
Number of substernal goitres	12
Malignancies	0
Abscesses	0
Post-operative X-ray	4
Pre-operative X-ray	1
Recurrences	5
Number of cases drained	100

TABLE No. 9

Institution No. 2	52 Cases
Number of patients having previous operations	2
Number of ligations	1
Number of cases drained	26
Number of substernal goitres	2
Recurrences	2
Malignancies	1
Abscesses	0
Post-operative X-ray	0
Pre-operative X-ray	1

TABLE No. 10

Institution No. 3	
Number of patients having previous operations	9
Ligations	1
Recurrences	9
Substernal goitres	3
Abscesses	1
Post-operative X-ray	0
Malignancies	2
Cases drained	78

Tables No. 8, 9 and 10 give various findings in the different institutions.

TABLE No. 11
437 GOITRES
3 INSTITUTIONS

Number having previous operations	24 or 5.49%
Ligations	8 or 1.83%
Substernals	17 or 3.89%
Malignancies	3 or .7%
Abscesses	1 or .2%
Cases drained	204 or 46.7%
Recurrences	16 or 3.6%
Post-operative X-ray treatments	4 or .9%
Pre-operative X-ray treatments	2 or .45%

Table No. 11 shows statistics of all three combined. The procedures, occurrences, and percentages of Table No. 11 will be discussed.

Of 437 goitres in the three institutions, 24, or 5.49% were cases having previous operations. This is not a high percentage, considering the average for the country. However, it is common knowledge that many recurrences continue to carry their disease without ever undergoing reoperation, due to fact that often the patient is not aware of the true facts. In some instances the operator hesitates to do the work over, realizing that, since thyrotoxicosis is essentially a chronic disease, there will be remissions as well as exacerbations. Some patients choose to continue with their lessened burden rather than make a return trip to the hospital for an operation. Some simply procrastinate.

There were only eight, or 1.83%, ligations, an indication that ligations are not much in vogue in these institutions. Some excellent thyroid surgeons practice ligations, and step operations, and more practice lobectomies. Each group, no doubt, proceeds with the idea of improving the patient to such an extent that further work can be done when most, or all, of the thyroid has been removed and a clinical cure has been effected. Some studies (Bartlett's) indicate that the improvement shown after ligation would have been effected by further general pre-operative care. Piecemeal operations (that is several) seem to the author to be putting the patient to too many hazards. I am aware that some men have reported excellent results. Lobectomies have been credited with saving many lives, one of the reasons given being that the liver is not let down too quickly.

Some authorities prefer to take the whole gland or none. They admit that at times it seems wise to pack the wound and do a secondary closure the following day, or even to stop the operation at any stage when it seems expedient.

One should fulfill all the requirements for safe thyroid surgery and do the complete operation at one time. Anything done to a thyrotoxic pa-

tient before all the requirements for safe thyroid surgery have been met is dangerous. This rule often applies to ligations and X-rays. If the patient cannot meet the requirements by the conventional method of treatment special measures should be carried out, and if these fail to produce satisfactory results, time should be given for a remission from natural causes. If the patient does not die, a natural remission is bound to occur. If the patient should die, the surgeon may console himself with the knowledge that in all probability had he intervened with any radical steps he probably would have brought on the death sooner.

In the author's experience, after adequate preparation, the more thorough the job the less post-operative reaction and the more prompt the recovery.

Seventeen substernal goitres are listed, but in all likelihood there were more substernals than the charts indicate. Several intrathoracic goitres were done to the author's knowledge. The important point to remember in an intrathoracic goitre is that the goitre carries the cervical fascia and the goitre's blood supply with it. Control the blood supply and then proceed to remove the goitre.

There were three malignancies, or .7%. In one large series of nearly 26,000 goitres, the incidence of malignancy was placed at .9%.

An important point to bear in mind with regard to malignancies of the thyroid is that they nearly all arise from nodular goitres. Another point is: Is there anything that might make one suspect malignancy? Any nodular goitre of long standing that suddenly begins to enlarge fast and is very hard is evidence enough to arouse suspicion of malignancy, and the surgeon should act accordingly. If all the malignant cells are removed before any metastases, then the patient ceases to have a malignancy. A third point is that carcinoma of thyroid has a special predilection for metastases to bone. This is not really of importance, because when such a condition is observed it is too late.

One abscess of the thyroid was drained. This case came down with marked constriction of the throat, chills and high fever. It is of the utmost importance in such cases to drain just as early as possible after fluctuation occurs.

Less than 50% of the 437 cases were drained. The tendency in this locality at present is to close the wound without drainage.

Four cases, or .9%, received post-operative X-ray therapy. Evidently these were subtotal

thyroidectomies. Only half this number (2) or, .45%, received pre-operative X-ray therapy.

TABLE No. 12

TYPES OF GOITRES

	Diffuse Toxic	Nodular Toxic	Nodular Non Toxic	Cystic	Mixed
Institution No. 1	150	54	51	25	4
At least 12 cases had myxedematous changes.					
Institution No. 2	36	9	2	3	2
Institution No. 3	60	20	18	3	0
	246	83	71	31	6
Hashimoto	Riedel	Tuberculosis	Syphilis	Cancer	
1 1?	2 5?	0 1?	0 0?	3 0?	

Table No. 12 lists the different types of goitres encountered. It will be noted that under the classification of diffuse non-toxic goitre no cases are listed. Four cases were reported as mixed goitre. This should be a good term since every goitre is a disease unto itself, and since quite often in a single section one can see areas characteristic of all types of goitre; that is, colloid, adenomatous, and exophthalmic goitre. All goitres eventually produce some nodules and cystic degeneration occurs frequently in nodular goitre.

There were at least 12 goitres where the patient had myxedematous changes. No doubt, this is more frequent than is generally supposed.

Various inflammations were encountered. One case was definitely diagnosed Hashimoto's disease, and there was one other questionable case.

There were two definite cases of Riedel's Struma, and five questionable cases.

One case of questionable tuberculosis of the thyroid was included. The microscopical findings were present but the condition was not proved by guinea pig inoculation.

No cases of syphilis of the thyroid were encountered.

TABLE No. 13
ASSOCIATED PATHOLOGY
INSTITUTION No. 1

Pregnancy	2 cases
Hypertension	4 cases
P. I. D.	20 cases
Acute cystitis	2 cases
Cancer of breast	1 case
Ureteral stricture	1 case
Acute coryza	1 case
Syphilis	10 cases
Diabetes	4 cases
Cardiac asthma	1 case
Cystocele	2 cases
Sinusitis	2 cases
Colitis	2 cases
Liver insufficiency	1 case
Thyroid heart disease	20 cases
Myxedema	1 case
Hydro nephrosis	1 case
Pilonidal-cyst	1 case
Bronchiectasis	1 case
Pernicious anemia	1 case

TABLE No. 14
ASSOCIATED PATHOLOGY
INSTITUTION No. 2

Malignancy of jaw	1 case
Syphilis	2 cases
Fibro myomata	1 case
Cardio toxicosis	1 case

INSTITUTION No. 3

Cancer of breast and fibroid	1 case
Tuberculosis	2 cases
P. I. D.	4 cases
Thyroid heart disease	4 cases
Arterio sclerosis and pulmonary fibrosis	1 case
Gall bladder disease	2 cases
Cystocele	1 case
Rectocele	1 case
Bronchiectasis	1 case
Syphilis	3 cases
Diabetes	1 case
Malaria	1 case
Pregnancy and premature delivery	1 case

Tables Nos. 13 and 14 list the associated pathology present in the various cases. The one encouraging thing about this table is that, in spite of the presence of other diseases being recognized, the needed thyroid surgery was done. It is likely that much more associated pathology was present than was recorded. It is almost inconceivable for one gland of internal secretion to be out of line without some other gland of internal secretion being affected. In spite of the fact that in almost every case there probably was some associated pathology, most records recorded none.

TABLE No. 15
COMPLICATIONS OF THYROIDECTOMY

1. Hemorrhage
2. Thyroid crisis
3. Stridor
4. Shock
5. Collapse of trachea
6. Tracheaitis
7. Pulmonary
8. Cardiac
9. Embolism
10. Alimentary tract
11. Infection
12. Serum
13. Acute hypothyroidism
14. Hyperthyroid psychosis
15. Tetany

Table No. 15 lists the complications of thyroidectomy. This table is shown so that it can be compared with the complications recorded for the entire 437 cases.

TABLE No. 16
COMPLICATIONS

Institution No. 1	
Bilateral abductor paralysis (hemorrhage)	1
Paralysis of cords	1
Diarrhoea	1

Tracheaitis	3
Parathyroid tetany	1
Institution No. 2	
Secondary hemorrhage after ligation	1
Tetany and paralysis of cords	1
Institution No. 3	
Pleuritic pain	1
Tracheaitis	4
Paralysis of cords	4
Post-operative hemorrhage	1
Parathyroid tetany	1

Table No. 16 indicates that few complications were listed. The tendency, it appears, is not to record complications unless they are severe and overwhelming.

Among the entire 437 cases, not one instance of serum collection was recorded, and we know that serum collection is common following thyroidectomy. Tracheaitis was listed seven times.

Where total thyroidectomy is done, tracheaitis is sure to follow, to some extent.

It is the tendency of most operators not to stress complications, and in this series of cases the patients either recovered or died, and unless the complications were severe no record of them was made.

Table No. 17 demonstrates that gas and local anaesthetics were most frequently used. Only once was chloroform used. Three cases were

given avertin and four received pentothal. Twenty cases received ether, the remainder either local anaesthetics or cyclopropane. The anaesthetic should be the one that has proven best in the operator's experience. It must be remembered, however, that any inhalation anaesthesia does some harm to the patient. This, within itself, is capable of precipitating a crisis. The fast and highly experienced operator has a wide latitude in his choice of anaesthetics due to the fact that his patient does not have to remain long under the anaesthetic.

The more toxic the patient, the more important is the anaesthetic. No thyrotoxic patient should receive an anaesthetic that markedly lowers the liver function.

When the surgeon has gained the complete confidence of his patient, and an adequate basal anaesthetic has been used, a local block anaesthetic may be particularly helpful, and in nearly every instance the patient can be returned to his room in just as good shape or better than he was the night before. As little as 8 c.c. of 2% novocaine with, or without, adrenalin (as indicated) works very satisfactorily for blocking the superficial cervical plexus and the descending branch of the 12th nerve that supplies the ribbon muscles.

TABLE No. 17
ANAESTHESIA

	N2O	Locals	Ether	Ethylene	Cyclo	Pentothal	Avertin & N2O	Avertin & CHCL 3	Avertin & Cyclo
Institution No. 1	0	119	8	4	149	3	1	0	0
Institution No. 2	4	12	3	9	22			1	1
Institution No. 3	2	56	10	8	24	1			
	6	187	21	21	195	4	1	1	1

CONTINUOUS CAUDAL ANALGESIA
IN OBSTETRICS

Eli Lilly and Company, Indianapolis, announces the release of a 16-mm. silent motion picture in color on the subject, "Continuous Caudal Analgesia in Obstetrics." The film is available to physicians for showing before medical societies and hospital staffs. It deals with the history, anatomy, and physiology of caudal analgesia and demonstrates the technic of use in obstetrics.

The film was made at the U. S. Marine Hospital, Staten Island, New York, by authorization of the Surgeon General, U. S. Public Health Service, and the demonstrations were carried out by the originators of the technic, Dr. Robert A. Hingson and Dr. Waldo B. Edwards.

COMMUNIQUE

To the Editor:

In complaine with your request I am sending you this letter with my proper address in the upper right hand corner. You will note that it is the same address you are now using.

I came through the * * * * campaign in one piece and am raring to go again.

I haven't seen any of the Arkansas men who are in * * * * but I expect to some day.

We are working pretty hard these days to prepare ourselves for a trip through Europe with our final destination—Tokio.

Thanks very much for the Journal—Give my regards to all at home.

Sincerely,
John M. Samuel

DIGEST OF NEW WAGNER BILL TO EXTEND SOCIAL SECURITY LAW TO INCLUDE MEDICAL AND HOSPITAL SERVICES

Now pending in the U. S. Congress is the long-promised proposal of Senator Wagner of New York to broaden the Social Security program to include medical and hospital services—a compulsory sickness insurance bill. The bill—S. 1161—has been referred to the Senate Committee on Finance. Following is an analysis of the measure prepared by the Bureau of Legal Medicine and Legislation of the American Medical Association and excerpts from an editorial on the proposal, published in the June 26, 1943, issue of *The Journal of the American Medical Association*.

It is suggested that all Arkansas physicians study this material in order to gain some idea of the bill's ramifications and the gigantic changes which would take place should it become a law. Now is the time when the physician must familiarize himself with the text and meaning of S. 1161. The time for action will come later—perhaps not in the too distant future.

Referred to generally as embodying an Americanized Beveridge plan but offered in Congress, according to Senator Wagner, "simply as a basis for legislative study and consideration," legislation was introduced, June 3, in the Senate by Senator Wagner, New York, for himself and Senator Murray, Montana, and in the House by Representative Dingell, Michigan, proposing to create a Unified National Social Insurance System (S. 1161; H. R. 2861). The Senate bill is pending in the Senate Committee on Finance and the House bill in the House Committee of Ways and Means.

The system proposed to be created will be financed in general from a trust fund established by a 6 per cent employee and a 6 per cent employer contribution on all wages and salaries, up to the first \$3,000 a year, paid or received after December 31, 1943. Included in this proposed system will be a system of public employment offices, increased old age and survivors' insurance benefits, temporary and permanent disability insurance benefits, protection to individuals in the military service, increase unemployment insurance benefits under a federalized unemployment system, maternity benefits, medical and hospitalization insurance benefits, a broadening of the basis of the existing social security program to embrace some 15,000,000 persons now excluded, such as farm workers and

domestic servants, employees of nonprofit institutions, independent farmers, members of the professions and other self-employed individuals, and a unified public assistance program. There follows an analysis of those provisions of the ninety page bill that appear to be of particular concern to medicine.

Disability Benefits Plus Medical Care

The bill broadens the existing social security coverage by providing for the payment of cash permanent disability benefits to beneficiaries. In addition to such cash benefits, the Social Security Board, through the Surgeon General of the Public Health Service, will be authorized to make provision for furnishing medical, surgical, institutional, rehabilitation or other services to disabled individuals, entitled to receive insurance benefits, if such services will aid in enabling such individuals to return to gainful work. Such services, it is contemplated, will be furnished "by qualified practitioners and through governmental and nongovernmental hospitals and other institutions qualified to furnish such services." In administering the provisions of this particular section of the bill, the Surgeon General and the Social Security Board will follow as far as applicable the procedure outlined by another section of the bill relating to medical, hospitalization and related benefits generally.

Medical, Hospitalization and Related Benefits in General

Section 11 of the bill proposes to add a new title to the Social Security Act, title IX, providing for a federal system of compulsory medical and hospitalization insurance for all persons covered under the old age and survivors' insurance, and their dependents. Each insured worker and his dependent wife and children will be entitled to receive general medical, special medical, laboratory and hospitalization benefits. In addition, the system is made elastic so that it may be enlarged in its coverage to admit other beneficiaries on a voluntary basis, such as self-employed individuals and employees of state and political subdivisions.

In order to appreciate the broad scope of this new title, consideration must initially be given to the meaning of the words and phrases used in it. The term "general medical benefit" means services furnished by a legally qualified physician, including all necessary services such as can be furnished by a physician engaged in the general practice of medicine, at the office, home, hospital or elsewhere, including preventive, diag-

nostic and therapeutic treatment and care, and periodic physical examinations.

The term "special medical benefit" means necessary services requiring special skill or experience, furnished at the office, home, hospital or elsewhere by a legally qualified physician who is a specialist with respect to the class of service furnished.

The term "laboratory benefit" means such necessary laboratory or related services, supplies or commodities, not provided to a hospitalized patient and not included as a part of the general or special medical benefit, as the Surgeon General of the United States Public Health Service may determine, including chemical, bacteriologic, pathologic, diagnostic and therapeutic X-ray and related laboratory services, physical therapy, special appliances prescribed by a physician, and eye glasses prescribed by a physician "or other legally qualified practitioner."

The term "hospitalization benefit" means (1) not less than \$3 and not more than \$6 for each day of hospitalization, not in excess of thirty days, which an individual has had in a period of hospitalization; (2) not less than \$1.50 and not more than \$4 for each day of hospitalization in excess of thirty in a period of hospitalization; and (3) not less than \$1.50 and not more than \$3 for each day of care in an institution for the care of persons suffering from chronic ailments. The exact amount of the benefit, between the minimums and maximums stated, will be fixed by the Surgeon General of the Public Health Service after consultation with the National Advisory Medical and Hospital Council to be created by the bill and after approval by the Social Security Board. In lieu of such compensation, the Surgeon General may, after approval of the Social Security Board, enter into contracts with participating hospitals for the payment of the reasonable cost of hospital service, at rates for each day of hospitalization neither less than the minimum nor more than the maximum applicable rates previously mentioned. Such payments will constitute full reimbursement, the bill provides, for the cost of essential hospital services, including the use of ward or "other least expensive facilities compatible with the proper care of the patient."

Panel of Physicians to Supply Medical Care

The Surgeon General will be required to publish and otherwise make known in each area to individuals entitled to benefits the names of general practitioners who have signified their willingness or desire to participate in the insurance program. Any legally qualified phy-

sician may so participate. A beneficiary may select any physician appearing on the panel to treat him subject to the consent of the physician selected, and may change such selection in accordance with such rules and regulations as may be prescribed. The Surgeon General may set maximum limits to the number of potential beneficiaries for whom a general practitioner may undertake to furnish medical benefits. Such limits may be nationally uniform or may be adapted to take account of "relevant factors."

The services of specialists will ordinarily be available only on the advice of the general practitioner. The Surgeon General will determine what constitutes specialist services and will also determine the qualifications of physicians as specialists "in accordance with general standards previously prescribed by him after consultation with the council and utilizing standards and certifications developed by competent professional agencies."

Payments for the Services of Physicians

Payments to general practitioners may be made (1) on the basis of fees for services rendered, according to a fee schedule approved by the Surgeon General; or (2) on a per capita basis, the amount being according to the number of individuals entitled to benefits who are on the practitioner's list; or (3) on a salary basis, whole or part time; or (4) on a combination or modification of these bases. The method of payment, subject to the approval of the Surgeon General, will apparently be determined in each area in accordance with the desires of a majority of the general practitioners collaborating with the insurance program.

Payments to designated specialists may include payments on salary (whole time or part time), "per session," fee for service, per capita, or other basis, or combinations thereof. Apparently the method of payment to be adopted for specialists will be determined by the Surgeon General.

Payments for medical services may be nationally uniform or may be adapted to take account of "relevant factors." In any area where payment for the services of a general practitioner is on a per capita basis, the bill provides that the Surgeon General shall distribute on a pro rata basis among the practitioners of the area on the panel those individuals in the area who, after due notice, have failed to select a general practitioner or who, having made a selection, have been refused by the practitioner.

The bill provides that in each area the provision of general medical benefit for all indi-

viduals entitled to receive such benefit "shall be a collective responsibility of all qualified general practitioners in the area who have undertaken to furnish such benefit."

Limitations on General Medical and Laboratory Benefit

The Surgeon General and the Social Security Board may determine for any calendar year or part thereof that every individual entitled to general medical benefit may be required by the physician attending him to pay a fee with respect to the first service or with respect to each service in a "spell of sickness" or course of treatment if it is believed that such a determination is necessary and desirable to prevent or reduce abuses of entitlement to such benefits. Maximum size of such fee may be fixed by the Surgeon General and the Social Security Board at an amount estimated to be sufficient to prevent or reduce abuses and not such as to impose a substantial financial restraint against proper and needed receipt of medical benefit. Likewise the Surgeon General and the Social Security Board may limit the application of such fees to home calls, office visits or both.

Participating Hospitals

For a hospital to participate in this insurance program, it must have been approved by the Surgeon General under standards prescribed by him after consultation with the council. A hospital to be approved must provide all necessary and customary hospital services and must be found to afford professional service, personnel and equipment adequate to promote the health and safety of individuals customarily hospitalized in such institution. The Surgeon General may approve or accredit a hospital for limited varieties of cases and may accredit an institution for the care of the "chronic sick." In determining the adequacy of the professional service, personnel and equipment of any such institution, the Surgeon General may take into account the purpose of such limited accrediting, the type and size of community which the institution serves, the availability of other hospital facilities, and such other matters as he may deem relevant.

Application for and Limitation of Hospitalization Benefits

No application by an individual for hospitalization benefits will be valid with respect to any day of hospitalization if the application is filed more than ninety days after such day, or with respect to any day of hospitalization for mental

or nervous disease or for tuberculosis after such diagnosis has been made. The maximum number of days in any benefit year for which any individual may be entitled to hospitalization benefit will be thirty. If, however, the funds in the special hospitalization benefit account fund to be created prove adequate, the maximum number of days may be increased to ninety by the Surgeon General and the Social Security Board, acting jointly.

Proposed Method of Administration

The Surgeon General of the Public Health Service will be authorized to take all necessary and practical steps to arrange for the availability of the medical, hospitalization and related benefits. He will be authorized to negotiate and periodically to re-negotiate agreements or co-operative working arrangements with appropriate agencies of the United States, or of any state or political subdivision thereof, and with other appropriate public agencies, and with private agencies or institutions, and with private persons or groups of persons, to utilize their services and facilities and to pay fair, reasonable and equitable compensation therefor.

The methods of administration, including the methods of payment to practitioners, the bill provides, shall (1) insure the prompt and efficient care of individuals entitled to benefits; (2) promote personal relationships between physician and patient; (3) provide professional and financial incentives for the professional advancement of practitioners, and encourage high standards in the quality of services furnished as benefits through the adequacy of payments to practitioners, assistance in their use of opportunities for postgraduate study, coordination among the services furnished by general practitioners, specialists, laboratory and other auxiliary services, coordination among the services furnished by practitioners, hospitals, health centers, educational, research and other institutions, and between preventive and curative services, and otherwise; (4) aid in the prevention of disease, disability and premature death, and (5) insure the provision of adequate service with the greatest economy consistent with high standards of quality.

National Advisory Medical and Hospital Council

The bill proposes the creation of a National Advisory Medical and Hospital Council, to consist of the Surgeon General of the United States Public Health Service as chairman and sixteen members appointed by him. The appointed mem-

bers will be selected from panels of names submitted by the professional and other agencies and organizations concerned with medical services and education and with the operation of hospitals and from among other persons, agencies or organizations informed on the need for or provision of medical, hospital or related services and benefits. Appointed members will hold office for four years, with the terms of office staggered. The appointed members will receive compensation at the rate of \$25 a day for time spent on official business of the council, and actual and necessary traveling expenses and per diem in lieu of subsistence.

This council will "advise" the Surgeon General as to (1) professional standards of quality to apply to general and special medical benefits; (2) designation of specialists; (3) methods and arrangements to stimulate and encourage the attainment of high standards through coordination of the services of general practitioners, specialists, laboratories and other auxiliary services, and through the coordination of the services of practitioners with those of educational and research institutions, hospitals and health centers, and through other useful means; (4) standards to apply to participating hospitals and to establishment and maintenance of the list of participating hospitals; (5) adequate and suitable methods and arrangements of paying for medical and hospital services; (6) studies and surveys of the services furnished by practitioners and hospitals and of the quality and adequacy of such services; (7) grants-in-aid for professional education and research projects, and (8) establishment of special advisory, technical, local or regional boards, committees, or commissions.

Relation to Workmen's Compensation Acts

The benefits provided by this bill will not be available with respect to an injury, disease or disability coming within the purview of any state or federal workmen's compensation act.

Dental, Nursing and Other Benefits

The bill devolves on the Surgeon General and the Social Security Board jointly the duty of ascertaining the most effective methods of providing dental, nursing and other needed benefits not contained in the pending bill and of determining the expected costs of such additional benefits. The bill contemplates that the Surgeon General and the Social Security Board will report the results of their findings, with recommendations as to legislation, not later than January 1, 1946.

Grants-in-Aid for Medical Education, Research and Prevention of Disease and Disability

The Surgeon General will be authorized to administer grants-in-aid to nonprofit institutions and agencies engaging in research or in undergraduate or postgraduate professional education. The purpose of these grants will be to encourage and aid the advancement and dissemination of knowledge and skill in providing benefits and in preventing illness, disability and premature death. Such grants-in-aid will be made with respect to each project (1) for which application has been received from a nonprofit institution or agency, stating the nature of the project and giving the reasons for the need of financial assistance in carrying it out, and (2) for which the Surgeon General finds, with the advice of the council, that the project shows promise of making valuable contributions to the education or training of persons useful to or needed in the furnishing of medical, hospital, disability, rehabilitation and related benefits or to human knowledge with respect to the cause, prevention, mitigation or methods of diagnosis and treatment of disease and disability.

This part of the program will be financed by setting aside a certain percentage of amounts expended for benefits from the Federal Social Insurance Trust Fund to be created by the bill. The amount to be set aside will equal 1 per cent of the total amount expended for benefits from the trust fund, exclusive of unemployment insurance benefits, or 2 per cent of the amount expended for benefits under title IX (relating to federal medical, hospitalization and related benefits), after benefits under that title have been payable for not less than twelve months, whichever is the lesser, in the last preceding fiscal year. The bill apparently leaves all the details with respect to these grants-in-aid to regulations to be promulgated by the Surgeon General after consultation with the council.

Self-Employed Individuals

Self-employed individuals may receive the benefits of the old age, survivors, and permanent disability and medical and hospital insurance by paying into the Trust Fund an amount equal to 7 per cent of the market value of their services rendered as self-employed individuals, after December 31, 1943, with respect to services in self-employment after that date, but not including that part of any remuneration for employment and the market value of services in self-employment in excess of \$3,000 for any calendar year.

Employees of States and Local Subdivisions

The bill authorizes the Social Security Board to enter into compacts with individual states or with political subdivisions for the purpose of extending old age, survivors, and permanent disability and medical and hospitalization insurance coverage to employees of such states or political subdivisions. To finance the benefits to be provided under such compacts, the bill requires such employer to pay a social security contribution equal to 3.5 per cent of the wages paid by it after December 31, 1943, and every individual beneficiary of such a compact a contribution equal to 3.5 per cent of the wages received by him after December 31, 1943, excluding any amount paid or received in excess of \$3,000 during any calendar year after December 31, 1943.

Bill as Viewed by Senator Wagner

On the floor of the Senate, June 3, Senator Wagner described the over-all objectives of his bill as follows:

The bill establishes a nation-wide system of public employment offices, to help war workers and war veterans to avail themselves of job opportunities, in private industry and on farms, throughout the country. It covers broadly the major economic hazards of average American families—the cost of medical and hospital care, and loss of income in time of unemployment, temporary sickness, permanent disability and old age. It improves the present old age insurance system and extends coverage to 15,000,000 persons now excluded, such as farm workers and domestic servants, employees of nonprofit institutions and the independent farmer, professional and small businessman. All these changes are established under a unified national system of social insurance, with one set of contributions, one set of records and reports and one set of local offices. Reinforcing the job guaranty in the Selective Service Act, the bill gives the returning veteran and his family paid-up benefit rights in every phase of this insurance protection. And, finally, the bill sets up an improved, unified system for grants-in-aid to the states for public assistance, on a variable matching basis, in place of the rigid categories under present law.

Prospect of Senate Consideration of the Bill

Senator Walter F. George, chairman of the Senate Committee on Finance, before which S. 1161 is pending, has been quoted as saying that his committee cannot possibly undertake to give consideration to the bill until late in the present session of the Congress and that if

that consideration is given, and if favorable action is taken by the committee, the measure will not reach the floor of the Senate until next year.

Comments of the Journal

Commenting editorially on the new Wagner bill, *The Journal of the American Medical Association* said in part:

"The Board of Trustees and the newly-created Council on Medical Service and Public Relations of the American Medical Association will, no doubt, give careful consideration in the near future to the policy of the Association regarding this specific measure. Arrangements will probably be considered for representation at hearings before the appropriate committees of the Senate and the House. Announcement made by the chairman of the committees of the Senate and of the House in charge of the bill indicate that this legislation is not likely to come for consideration previously to the next session of Congress. In the meantime physicians should inform themselves concerning its genesis and its objectives.

"In its evolution the Wagner-Murray-Dingell bill stems from the National Health Conference of 1937, the Wagner bill which followed that conference, and the report of the National Resources Planning Board. Essentially in its medical aspects it is a compulsory sickness insurance bill and an attempt to translate the proposals of the Social Security Board into a technic of action. Inquiry of reliable sources in Washington indicates the probability that the actual designers and authors of the bill included I. S. Falk, director of the Bureau of Research and Statistics of the Social Security Board of the Federal Security Administration; Mr. Wilbur J. Cohen, technical adviser to the Social Security Board, and Senator Wagner's secretary, Mr. Philip Levy. A statement issued by William Green, president of the American Federation of Labor, says 'The measure, which is the most comprehensive attempt yet made to establish postwar security in this country, is the fruit of a five-year study by experts on the staff of the American Federation of Labor, which will give the proposed program full sponsorship and support.' Inquiry also reveals that, as far as can be determined, representatives of the medical profession, either within or without the government, were not consulted in the development of the medical provisions. Evidence of this failure to consult the medical profession appears in the language of the proposed bill, since it speaks twice of a 'spell of sickness.' The word 'spell,'

thus employed, does not appear in English dictionaries except as a colloquialism in Webster, and the term is seldom, if ever, used by any one educated in medicine.

"A study of the analysis by the Bureau of Legal Medicine and Legislation will reveal to the medical reader the terms of the proposal. Speaking bluntly, however, the measure apparently attempts to avoid the innumerable difficulties involved in developing a government controlled medical service by making the Surgeon General of the Public Health Service, whoever he might be, a virtual 'gauleiter' of American medicine. Indeed, it is doubtful if even Nazidom confers on its 'gauleiter' Conti the powers which this measure would confer on the Surgeon General of the U. S. Public Health Service. Here are some quotes:

" 'Extensive Powers Granted

" 'The Surgeon General of the Public Health Service is hereby authorized and directed to take all necessary and practical steps to arrange for the availability of the benefits provided under this title. . . .

" ' . . . The Surgeon General is hereby authorized to negotiate and periodically to re-negotiate agreements or cooperative working arrangements with appropriate agencies of the United States, or of any state or political subdivision thereof, and with other appropriate public agencies, and with private agencies or institutions, and with private persons or groups of persons, to utilize their services and facilities and to pay fair, reasonable and equitable compensation for such services or facilities. . . .

" 'There is hereby established a National Advisory Medical and Hospital Council to consist of the Surgeon General as Chairman and sixteen members to be appointed by the Surgeon General.

" 'The Surgeon General shall publish and otherwise make known in each area to individuals entitled to benefit under this title the names of general practitioners who have agreed to furnish services. . . .

" 'Services which shall be deemed to be specialist services shall be those so designated by the Surgeon General, and the practitioners from among those included in paragraph 1 above who shall be qualified as specialists and entitled to the compensation provided for specialists shall be those so designated by him as qualify to furnish such specialist services. . . .

" 'Payments from the Trust Fund to general practitioners . . . shall be made on the basis of fees for services rendered to individuals en-

titled to benefits, according to a fee schedule approved by the Surgeon General. . . .

" 'The Surgeon General may prescribe the maximum limits to the number of potential beneficiaries for whom a practitioner may undertake to furnish general medical benefit. . . .

" 'The Surgeon General is hereby authorized to establish necessary and sufficient hearing and appeal bodies. . . .

" 'The Surgeon General shall publish a list of institutions found by him to be participating hospitals. . . . Inclusion of an institution upon such a list shall, unless and until withdrawn by him, be conclusive. . . .

" 'The Surgeon General and the Social Security Board may . . . determine for any calendar year . . . that every individual entitled to general medical benefit may be required by the physician furnishing such benefit to pay a fee with respect to the first service or with respect to each service in a spell of sickness or course of treatment.

" 'The Surgeon General and the Social Security Board jointly shall have the duty of studying and making recommendations as to the most effective methods of providing dental, nursing and other needed benefits. . . .

" 'The Surgeon General, after consultation with the Social Security Board, and with the approval of the Federal Security Administrator, shall make and publish such rules and regulations . . . necessary to the efficient administration. . . .

" 'The term "laboratory benefit" means such necessary laboratory or related services, supplies or commodities . . . as the Surgeon General may determine, including chemical, bacteriological, pathological, diagnostic and therapeutic X-ray, and related laboratory services, physiotherapy, special appliances prescribed by a physician, and eye glasses prescribed by a physician or other legally qualified practitioner.

" 'With respect to inclusion in the list of participating hospitals the Surgeon General may accredit a hospital for limited varieties of cases and may accredit an institution for the care of the chronic sick. . . .

" 'This list is not all inclusive. There are many other points which space does not permit to be included in an editorial.

" 'Free Choice'—Perhaps

" 'In offering the bill, its proponents emphasize that it provides for free choice of doctors; free choice of a doctor means, of course, free choice of doctors willing to engage in this type of work.

" 'The proposed measure has already been dis-

cussed editorially by such newspapers as the Washington Star and the Chicago Daily News, both of which pointed out that its passage would accumulate, at least for the present, deductions from many workers' wages of 20 per cent for income tax, 10 to 25 per cent for war bonds, 12 per cent for social security and such other special deductions as are already made in many individual plants. According to these figures there would be a minimum deduction of 42 per cent and a maximum deduction of 57 per cent of the worker's wages. The Chicago Daily News said:

"We suspect that zeal for social security in the sweet by and by will have a hard time surmounting the shriveled paycheck already here, with the future shrinkage now plainly in sight'."

A LETTER FROM SURGEON-GENERAL PARRAN

July 19, 1943.

Doctor R. B. Robins,
111 Van Buren Street,
Camden, Arkansas.

Dear Doctor Robins:

I am in receipt of your letter of July 10 requesting my comment on Senate bill 1161, and asking whether I favor it or not.

There are a number of considerations which would prevent me from accepting this bill as it stands at present. There is, for example, the question as to whether a compulsory health (or sickness) insurance scheme is the best method for improving the health of the people. I believe other plans should be explored and the advantages and disadvantages of the several methods freely discussed.

I feel also that everything possible should be done to elicit constructive suggestions from outstanding leaders in the medical profession, and that the physicians now serving in the armed forces should have an opportunity to express themselves regarding plans which would greatly affect their professional careers.

There are a number of other questions which I feel should receive most careful consideration before specific action is taken, but the above may be sufficient for any purpose you have in mind.

Sincerely yours,

Signed: Thomas Parran,
Surgeon General,
U. S. Public Health Service.

COMMUNIQUE

To the Editor:

Your letter of June 22nd just came in and properly addressed as above. Read with interest extracts from a letter of mine which appeared in the June Journal. Had to read the footnote to be sure that was my "stuff." Well, summer has come but has not been as hot where we are as it has been in the States. Will be quite warm during the day but cools off at night with a gentle breeze. My chief diversion is a good swim in the ocean at least once a week at a good beach a few miles away. Note with some pride that a Fort Smith citizen, Lt. Col. Darby, has just been decorated with the D. S. C. Know you folks are proud, too. So far U. S. troops have suffered no severe epidemics in this theatre. Some malaria and bacillary dysentery. It is necessary for all to be constantly on guard against such infections where only primitive sanitation exists.

Regards,

Lt. Col. A. M. Washburn, M. C.

COMMUNIQUE

To the Editor:

Out here we are anxious to hold on to every home contact. The Journal is more than the routine publication we received on the first of the month. You'll pardon me if I "stumble" over myself to give you my correct address.

Sorry I can't tell you more about ourselves. Hope to do so in the future. Thanks for the interest you are showing in the doctors overseas. The Journal will be appreciated.

Hugh Mobley

COMMUNIQUE

To the Editor:

Enjoy the Journal very much. The above address is my latest and finds me as a battalion surgeon. Still proud to be with the famous * * * Regiment of the crack * * * Marine Division.

The mail comes through very quickly and I look forward to the Journal to see where some of the Arkansas medicos are helping to make history.

Regards to all there.

Sincerely,

Geo. F. Stocker.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

OUT of 860 colleges and universities which received the annual survey questionnaire of the Tuberculosis Committee of the American Student Health Association, 488 replied and 311 reported tuberculosis case-finding programs in operation. In view of the heavy losses in student health personnel and other serious disturbances experienced by many schools because of the war, this report represents encouraging progress in tuberculosis control among our institutions of higher education. It is significant that colleges with a definite control program discovered new cases of pulmonary tuberculosis almost eighteen times as frequently as did those colleges with no program.

COLLEGE CAMPUSES IN THE FIGHT AGAINST TUBERCULOSIS

The Twelfth Annual Report of the Tuberculosis Committee of the American Student Health Association gives striking proof of the value of a tuberculosis control program as a regular part of student health service. In the 311 progressive colleges and universities (total student enrollment, 558,075) reporting such programs, 744 new cases of tuberculosis were discovered, a rate of 133.5 new cases per 100,000 students. At 177 colleges (total student enrollment, 146,000) which provided no such programs, 11 new cases came to light, a rate of 7.5 per 100,000 students. Twenty-two food handlers were found to have pulmonary tuberculosis, and among faculty and other administrative officers, 40 new cases were discovered, thus bringing the total of new cases found in colleges during the school year 1941-1942 to 817.

Few diseases impose such costly and far-reaching penalties for public or personal failure to provide early diagnosis as does tuberculosis; yet the majority of institutions of higher education in this country still fail to employ modern tuberculosis case-finding methods, which are simple and not expensive. The years of disability and suffering and the financial costs involved will reach staggering proportions, and there will be numerous deaths whenever we neglect early diagnosis of tuberculosis.

It is estimated that the complete cost of finding an undiscovered case of tuberculosis among college students on now unprotected campuses might run as high as \$166. This may seem expensive to some, who do not take into account the

social and economic values involved in the early diagnosis of the disease. Failure to provide modern case-finding programs, however, will invariably prove far more costly to unfortunate individuals, families and communities, and can never redound to the credit of a negligent institution.

The tuberculin test provides the most sensitive and reliable index of the prevalence of tuberculous infection. In the young adult group, for the country as a whole, 21.8 per cent of students react to tuberculin, the east and west coast sections having a higher infection rate than other sections of the country.

Many of the older, largely exploded, ideas relating to tuberculosis seem still to be firmly lodged in the minds of many people. The belief is all too prevalent that early tuberculosis gives rise to early symptoms. Certain institutions report various procedures for the follow-up of "suspects." "Weighing at frequent intervals," "frequent temperature readings," are among the more common of these. The "suspects" are usually those students who are markedly underweight. The Committee therefore feels justified in emphasizing again the fact that the tuberculin test and the chest X-ray provide the only adequate means for the early detection of presymptomatic tuberculosis in the vast majority of cases.

Although it is not possible to speak in exact terms of the incidence of tuberculosis as applying to the country's student population, reports available to the Committee seem to indicate a decline of approximately 30% in its prevalence among

college students during the past six years. This may be on the conservative side, for during this period reports from many of the larger institutions conducting excellent case-finding programs indicate an extension of these procedures to include a higher percentage of their students. It is evident that more students are being examined each year and the technics employed have improved and become more effective.

That there are various technics used in tuberculin testing is shown in Table 1. The Mantoux intradermal method continues to lead all others while P.P.D. and O. T. are fairly even choices in testing materials. A comparatively large number of colleges use the two-dose technic.

TABLE 1

Testing Technics in 254 Colleges Reporting Tuberculin Testing Programs, 1941-42	
Testing Method:	
Mantoux intradermal	182
Vollmer patch test	54
Pirquet	4
Combined Mantoux and patch test	3
Unspecified	11
Testing Material:	
Purified protein derivative	93
Old tuberculin	89
Combination of the two	1
Testing Dosage:	
Two-dose technic	63
Single large dose	35
Single intermediate dose	37
Single small dose	37
Combination of dosages	2
Testing Routine:	
New students and all negative reactors annually.....	63
New students only (no retesting)	49
New students and all seniors	29
Test optional (available to all annually).....	47
Other testing routines	46

Sixty-six colleges report the ideal annual X-ray of positive reactors. The various X-ray procedures reported are indicated in Table 2.

TABLE 2

X-Ray Procedures Reported by Various Institutions, 1941-42	
254 Colleges Reporting Tuberculin Testing Program:	
Positive reactors x-rayed once	74
Positive reactors x-rayed annually	66
X-ray optional (acceptance general)	60
X-ray optional (acceptance not satisfactory).....	10
Other x-ray routines	19
Fluoroscope used routinely to supplement x-ray	38
Fluoroscope used exclusively (chest x-ray when indicated)....	12
57 Colleges Reporting No Tuberculin Testing Program:	
Chest x-ray for all new students	22
Chest x-ray for all students annually	9
Other routine x-ray programs	26

During the school year 1942-1943 the Committee enlisted the cooperation of a group of eastern colleges in a study of entering students approximating 10,000 in number. Information concerning each student includes age, home address, name and location of secondary school attended and whether a private, public, or parochial school; tuberculin test technic and results; and X-ray findings. It is hoped that this survey may continue without interruption for a period of ten years or longer, thus providing data indi-

cating differences in the prevalence of tuberculous infection among students from various states and various home communities, accurate yearly comparisons, as well as supplying an index of any changes in the prevalence of tuberculous infection among students in this area.

Tuberculosis Among College Students, H. D. Lees, M. D., The Journal-Lancet, April, 1943.

COMMUNIQUE

To the Editor:

The Journal has been arriving fairly regularly up until the past few months and the delay recently has been due to my own carelessness for not informing you of my recent change of address. The old address was correct in all respects and while at that post The Journal would arrive in about three weeks after mailing, but now due to the fact that it is necessary that it be forwarded, it is usually about a month before I receive it.

Many parts of the magazine are of special interest to me, especially the news items concerning the various members. I would certainly appreciate it and I know that many others would, too, if the names and addresses of the members could be published in The Journal. (Editorial Note—Censorship regulations prohibit such publication). There are many with whom I desire to communicate but so far have been unable to find out their addresses.

In case such a list cannot be published, I would appreciate a list of the names of the men who are in this area. I have seen a few of the fellows and I know that there are many more in the * * *.

Thank you very much,
Ewing M. Nixon

COMMUNIQUE

To the Editor:

The Journal of the Arkansas Medical Society has been coming right along regularly. I always enjoy The Journal and it helps me to hear about many of my friends where otherwise I would not. The Journal seems like a long letter from home and I never fail to read it "from civer to civer."

Any day I will be glad to resume the practice of urology in Little Rock. I have a fine urology department here and am chief of the urology section.

Best regards to all.

Sincerely,
T. Duel Brown,
Major, M. C.,
Air Base Hospital,
Lincoln, Nebraska.

Warrio

THE military doctor of World War II — unarmed yet unafraid — moves up shoulder to shoulder with the combat troops. Bayonet charge . . . parachute landing . . . beach-storming from raiding barges . . . constantly, the medical officer proves that he is every inch a fighting man.

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1st in the Service

*With men in the Army, the Navy, the Marine Corps, and the Coast Guard, the favorite cigarette is Camel. (Based on actual sales records.)

New reprints available on cigarette research—Archives of Otolaryngology, February, 1943, pp. 169-173—March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, One Pershing Square, New York 17, N. Y.

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THE JOURNAL

OF THE

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EDITORIALS

ARMED FORCES MUST HAVE 6,000 MORE PHYSICIANS BY JANUARY 1

Journal of A. M. A. Calls on the Profession
To Fully Meet the Responsibility That
Has Been Placed On It

The armed forces must have 6,000 additional
physicians by Jan. 1, 1944, **The Journal of the
American Medical Association** reports in an edi-
torial in its August 7 issue. **The Journal** says:

"At a conference of the Directing Board of the
Procurement and Assignment Service for Phy-
sicians, Dentists and Veterinarians, held on July
31, with the War Participation Committee of the
American Medical Association and in the pres-
ence of Mr. Paul V. McNutt, chairman of the
War Manpower Commission and representatives
of the Army and Navy medical departments and
the Public Health Service, it became apparent

that the medical profession must produce toward
the winning of the war an additional six thousand
physicians for the armed forces before Jan. 1,
1944. Pursuant to a realization of this objective
a directive has gone to the generals in command
of the various service commands authorizing
them to induct into the service physicians be-
tween the ages of 38 and 45 who have been
declared available by the Directing Board of the
Procurement and Assignment Service for Phy-
sicians, Dentists and Veterinarians and who are
otherwise subject to Selective Service.

"The needs of the armed forces are real. The
members of the War Participation Committee
raised with the representatives of the various
governmental agencies all the questions that have
from time to time challenged the need; the chal-
lenge seems to have been met effectively. In-
deed, the intimation was made clear that the
needs of the armed forces will be met by specific
regulations of the Selective Service Administra-
tion or the enactment of necessary legislation if
required. All physicians up to 45 years of age
who have been indicated as available have there-
fore placed on them now the responsibility for an
immediate decision as to their enlistment with the
armed forces. The need is so positive that ques-
tions of essentiality of men in positions of teach-
ing and research and in industrial medicine are
likely to be rigidly reviewed in the near future
with a view to extracting from civilian life every
one that can be spared.

"As the war continues and intensifies new
needs for the services of the medical profession
become apparent. An army in motion and one
engaged in the kind of aggressive combat that
now concerns our armed forces needs physicians
in even greater numbers than have heretofore
been demanded. Many thousands of interned
aliens and prisoners are now the burden of the
United States and must be given medical care.

"If there is any physician who still hesitates
under these circumstances, he should realize the
added advantage to him of accepting now the
commission that is proffered. Should it become
necessary in the near future, as seems quite likely,
to enlist new activity by the Selective Service
Administration and the Officers' Procurement
Service to bring in the six thousand physicians
that are so certainly required, those recruited
by that technic will inevitably begin their service
with the minimum commission that is offered,
namely that of first lieutenant. Until that technic
is installed, the men of special competence and
of years beyond those of the recent graduate
have the assurance of careful consideration and

a commission more nearly in accord with age and experience.

"The call here made has the approval of the Directing Board of the Procurement and Assignment Service and of the War Participation Committee of the American Medical Association. The medical profession may well be proud of the fact that it has been the only group given, by directive of the President, the responsibility of maintaining service in civilian life and at the same time supplying the needs of the armed forces. Let us not fail in meeting fully the trust that has been placed upon us."

TAX ESTIMATE DUE SEPTEMBER 15TH

Under the new income tax law physicians and others now under a wage-earner status are required to file an estimate of their 1943 income taxes. At the same time one-quarter of the total estimated tax due must be paid. Congress failed to place some of the taxpayers, physicians and other professional groups being among the number, on a current tax basis.

The new legislation is of particular interest to physicians in that their income from professional fees may vary greatly in any one tax period and estimation of the tax will be rather difficult.

The income tax installments paid on March 15th and on June 15th of this year will be applied to the 1943 tax rather than to 1942 tax.

In computing the estimated tax, the physician should estimate his actual income tax and then add to that sum five per cent of his net income (the Victory tax) which will be his total estimated tax for the year. Should the total tax for 1943 be less than the amount due in 1942, the estimated tax will be the amount due on 1942 taxes. The present income tax law forgives 1942 or 1943 income taxes up to 75 per cent, whichever is the smaller.

Failure to file a declaration on time carries a 10% penalty as does failure to estimate your tax properly. If as much as 80 per cent of your actual total tax is greater than the amount estimated, the doctor is open to a penalty of the difference between 80 per cent and the estimated tax or 6 per cent of the difference. Thus, your estimated tax must be within 80 per cent of the actual tax to avoid penalty. How doctors are to avoid this penalty because of fluctuations in their income is difficult to perceive.

Compilation of current tax payment promises to be even more difficult than actual tax payment has been in former years. The need for accurate and complete records is now paramount.

Physicians are advised to consult the income

tax department or a qualified income tax counselor on their personal income tax problems prior to filing of the return.

SENATE BILL 1161

Introduced in the closing days of the recent congressional session, this bill by Senator Wagner provides, in brief, for free medical (general and special), laboratory and hospital care for more than one hundred million citizens of the United States. Full and dictatorial powers are placed in the hands of the Surgeon General, United States Public Health Service, to (1) hire doctors and establish rates of pay, (2) establish fee schedules, (3) establish qualifications for specialists, (4) determine what hospitals or clinics may provide service, and (5) to determine the number of individuals for whom any physician may provide service.

It is most evident that with the passage of this bill, the entire system of American medical practice will be abolished.

Physicians are urged to study the bill, inform themselves fully of its provisions, and then to discuss it with their Representatives and Senators. An informative pamphlet on the provisions of the bill has been mailed every physician by the National Physician's Committee. An analysis of the bill appeared in the June 26th issue of The Journal of the American Medical Association and is reprinted in this issue of The Journal of the Arkansas Medical Society. This issue also contains a letter from Dr. Thos. Parran, Surgeon General, United States Public Health Service, giving his views on the proposed legislation.

Medicine has a vital stake in this matter. Each physician is obligated to inform himself and then to inform others of the effects of such legislation.

EDITORIAL COMMENT

WRITE A LETTER

The Journal is pleased to publish in this issue a number of letters from our members now with the armed forces. All agree that news from home is most welcome. It seems that those of us at home owe them a short newsy letter at frequent intervals. Because of censorship requirements, The Journal is not permitted to publish the addresses of those members who are in service overseas but letters to these physicians sent in care of The Journal will be promptly forwarded.

Altogether now, give the editor "writer's cramp" from re-addressing all these letters.

PROCEEDINGS OF SOCIETIES

The Craighead-Poinsett County Medical Society met in Cash August 5th for a fish fry as guests of J. H. McCurry. The following program was presented: "Nicotinic Acid," V. D. McAdams, Cord; "Pending Legislation on Social Security," S. J. Allbright, Searcy, and "Something Interesting," A. G. Modelevsky, Jonesboro.

Dr. and Mrs. M. C. Crandall and Dr. and Mrs. H. E. Cockerham were hosts to a recent meeting of the Southeast Arkansas Medical Society at Lake Chicot. Following a fish fry the meeting was addressed by Dr. McSparrin of the Jerome Relocation Center and by Dr. Montgomery, Greenville, Mississippi.

The Pope-Yell County Medical Society met in dinner session at St. Mary's Hospital, Russellville, August 12th, for the following program: "Varicose Veins," Ralph E. Crigler, Fort Smith. W. O. Young, Jr., Secretary.

"WAR OR NO WAR—

Depression or no depression, in good times and in bad," Mead Johnson & Company are keeping the faith with the medical profession. Mead products are not advertised to the public. If you approve this policy, please specify **Mead's**.

OBITUARY

JAMES SILAS KOLB, age 79, died at his home in Clarksville August 9th after an illness of two weeks.

Born in Lowens County, Mississippi, he came to Johnson County at the age of 14 and graduated from the University of Arkansas School of Medicine in 1892. He first practiced in the Spring Hill community and moved to Clarksville in 1903. At the time of his death he was the oldest physician in the county. He was a member of the Masonic Lodge, receiving that order's Fifty-Year Button in 1942, and was affiliated with the Presbyterian Church. Long active in the affairs of organized medicine, he was elected to honorary membership in the Johnson County Medical Society and in the Arkansas Medical Society in 1937. He retired from active practice in 1939. Surviving relatives are his wife, three daughters and three sons, one of whom, Capt. James M. Kolb, is on duty with the armed forces.

PERSONALS AND NEWS ITEMS

Ruth Harris Junkin has moved from Little Rock to Pine Bluff, Arkansas.

Lt. Philip T. Cullen, Little Rock, is now stationed at the Station Hospital, A. A. F. T. T. S., Sioux Falls, South Dakota.

Howell Brewer, Hot Springs National Park, has been promoted to Colonel and is in command of the 186th Station Hospital overseas.

Capt. Hugh J. Mayfield, El Dorado, is now on duty with the Medical Detachment, 38th Infantry, Camp McCoy, Wisconsin.

Capt. James M. Nisbett is now on duty with the Armed Forces Induction Station, Lafayette, Louisiana.

A. A. Blair, Fort Smith, recently spent a vacation in Alabama.

BORN—On July 16th, a son, George Allan, to Capt. and Mrs. Wilfred R. Parsons, Fort Sam Houston, Texas.

Maj. E. J. Ritchie, North Little Rock, is now stationed with the 59th Fighter Group, A. A. F. Thomasville, Georgia.

Lt. Chas. W. Rasco, Jr., DeWitt, is now stationed at Station Hospital, A. A. B., Scotts Bluff, Nebraska.

Capt. Merle Woods, Huntington, stationed overseas for the past year, recently visited his home en route to a new assignment at Randolph Field, Texas.

Dr. and Mrs. Virgil Payne, Pine Bluff, spent a recent vacation in Colorado.

Friedman Sisco, Springdale, has been promoted to Major, Medical Corps, A. U. S. Major Sisco is now stationed overseas.

Hugh Mobley, Searcy, now serving overseas, has been promoted to major.

Lt. Cmdr. Fred H. Krock, Fort Smith, has been assigned to overseas service.

Capt. Merl T. Crow, Warren, is now in service overseas.

BORN—to Lt. Col. and Mrs. James W. Branch, Camp Cooke, California, a son, Robert Matthews, on August 6, 1943.

Vern E. Morgan has become associated with the Pulaski County Health Department as clinician in venereal disease.

H. K. Abrams, Texarkana, discussed typhus fever in a radio interview recently.

Geo. S. Atkinson, formerly of Blytheville and recently in the military service, has located at Morrilton.

D. L. Owens recently addressed the Chi Sigma Sorority at Harrison on "Cancer."

W. A. Snodgrass, Jr., formerly of Pine Bluff, has located at El Dorado.

Roy I. Millard has enlarged his office building at Russellville.

L. A. Wilcox, Little Rock, discussed the health program of the Arkansas Ordnance Plant over radio station KARK, Little Rock, recently.

J. J. Baker has been appointed city health officer at Magnolia.

O. B. McCoy, Harrison, has been promoted to Captain, Medical Corps, Army of the United States, and assigned to Stinson Field Air Depot Training Station at San Antonio.

Lt. John W. Harper, El Dorado, is now on duty with the Marine Corps at Camp Pendleton, California.

H. H. Smith, Fort Smith, spent an August vacation in New York state.

D. W. Goldstein, Fort Smith, recently visited medical centers in Minnesota and Chicago.

Lt. Frank C. Maguire, Jr., Augusta, is now stationed at Fort Riley, Kansas.

R. J. B. Hibbard, State Sanatorium, has passed examinations as a Diplomat of the American Board of Internal Medicine.

COMMUNIQUE

To the Editor:

As requested in your special bulletin of June 22nd, I am submitting my correct military address.

I have been receiving my Journal regularly and must say it is with pride that I read what the Arkansas doctors are doing at home and in the services. Have not seen a doctor from Arkansas in the Seventh Service Command since the change putting Arkansas into the Eighth Service Command, so The Journal is my "home contact."

Incidentally, I am in charge of the outfit I am with and it is my firm belief that the Army can produce as large and throbbing type of headache as can any disease known to man.

In the future I will keep you informed on my change of address and thanks very much for keeping The Journal coming to me.

Very truly yours,

Carl C. Hanchey, M. C.,
Major, M. C.,
266th Station Hospital,
Fort Snelling, Minnesota.

COMMUNIQUE

To the Editor:

I look forward to receiving The Journal with its large budget of Arkansas news and interesting articles so I hasten to send my correct address as requested in your letter.

Many thanks for your greetings. I send my best wishes to you personally and to the Society. It's surprising how frequently I meet a friend from Arkansas. They do get around and seem to be doing a good job.

Sincerely yours,

Carroll F. Shukers.

COMMUNIQUE

To the Editor:

Just received your letter of June 22nd and even though it was a form letter it makes me feel good to hear from you folks back home.

My last change of address was made in January at which time I went aboard the best ship in the Fleet. Have had plenty of interesting work and enjoy it thoroughly.

I have received both the January and February copies of The Journal since returning.

John M. Hundley.

RANDOM THOUGHTS OF THE SECRETARY

July 19th. Comfortably situated in Estes Park, where there is much of Coca-Cola but little of beef; the usual cool Colorado temperature; plenty of opportunity to hike about the village but no opportunity to drive the Trail Ridge road. Private automobiles seem mostly those of residents, but we observe the cars of two physicians, the caduceus rather blatant, it seems, since they are licensed in Texas and Illinois and we are unfamiliar with any gasoline regulation which legally permitted the trip they have made.

July 27th. Riding in artificial Colorado weather today from Kansas City home we enjoy the book length story of Cory Wassell's epic achievement and learn quite a few things about this physician.

July 28th. Back to work with the weather hotter than ever before this summer, and never does it seem that there was so much to be done.

August 4th. Today in Malvern with the Hot Spring County members where we find Prickett the target of as much heckling as is our burden. The problems of medical care in the section fully discussed, comes lunch at the remaining Barlow Hotel personally operated, where the reputation is fully maintained. In the afternoon to the spectacular Jones Mills where a doctor is sought, and then rapidly about curves and down hills to Butterfield with Pool as chauffeur to catch the Rock Island at Butterfield. In Little Rock we join Shuffield, Watson and Gebauer for a really good steak and much pleasant conversation.

August 12th. With Crigler as traveling companion, tonight with the Pope-Yell County Society where Crigler speaks in scientific manner and we discuss various side-lights of medical practice in these days. The interest and enthusiasm of these physicians in their county society is most stimulating and we should like to meet with them at more frequent intervals. Millard asks us, "How we ever get around to do what we have to do?" a question which we ponder all the way home.

August 18th. Kilbury, now seeking specimens by disinterment, visits today, reporting the performance of an autopsy even though he left his instruments at home. Too, he admits the interest of Kilbury, Junior, in roentgenology, convincing us that the name of Kilbury will shortly be of medical importance in Little Rock. The Chamberlains drive him to Van Buren, all hoping that he had a seat on the train.

CAUDAL ANESTHESIA IN OBSTETRICS *

During the last century many methods for the relief of the pains of childbirth have been advocated. Inhalation anesthesia, first suggested by Sir James Simpson, was followed by the administration of drugs, orally, or by hypodermic injection, or by rectum. All methods were partially successful, but all had their peculiar dangers among which were the many babies born more or less asphyxiated.

Recently Hingson and Edwards have reported a new method for producing painless childbirth

by injecting a cocaine derivative into the caudal canal at various intervals, thus producing analgesia during labor and anesthesia for delivery. Experience with this method of procedure and an analysis of 218 cases is presented on page 1023 of this issue * by Drs. Francis R. Irving, C. Albertson Lippincott, and Frank C. Meyer, of Syracuse, New York, in which contribution the authors, in a preliminary report, enumerate the disadvantages and contraindications for use of this procedure.

In 218 cases, twenty-nine instances of fetal distress, or 13.3 per cent, were noted; in 118 cases, a sustained fall in blood pressure in twenty-two, or 18.6 per cent, was found; of the twelve cases of fetal distress in the last 118 cases, nine, or 75 per cent, "occurred in patients manifesting a sustained low blood pressure. In each of the remaining three cases there was clear obstetric explanation for the fetal distress.

"One stillbirth is presented for which there is no apparent obstetric reason and which was probably a result of the caudal anesthesia."

These disadvantages and contraindications should be carefully studied by those who contemplate the use of this method. Aside from the high percentage of fetal distress and sustained drop in maternal blood pressure, it should be considered that the invasion of the caudal canal is, in itself, a major surgical procedure. "Since most of the dangers, drawbacks, and untoward effects have been associated with certain technical difficulties which could not be foreseen in the early phases of the work by even experienced physicians, it is suggested that, for the present, at least, the use of the method be confined to institutional practice by persons trained and experienced in caudal anesthesia."

Let us reiterate. The method of giving the anesthesia is a major surgical procedure. A patient receiving continuous caudal anesthesia requires meticulous care and frequent observation of blood pressure and fetal heart rate. The technic is relatively new. A few undesirable results following its use by those not fully aware of the hazards may bring about unwarranted condemnation of what may be a helpful and valuable procedure. Its use should be restrained. It seems at present to be a proper procedure only for larger institutions possessing well-trained assistants, especially with respect to the technic of anesthesia of this kind. Considerably more investigation seems warranted before it is made generally available to the public.

* From the New York State Journal of Medicine, June 1, 1943.

WOMAN'S AUXILIARY NEWS

Mrs. Fred Hames was re-elected president of the auxiliary to the Jefferson County Medical Society when it met in the home of Mrs. W. S. Bruce, July 8th.

Other officers elected at the meeting were Mrs. O. G. Clark, vice president, and Mrs. Ross Maynard, recording secretary, with Mrs. W. H. Bruce, re-elected corresponding secretary, and Mrs. J. S. Spillyards, re-elected treasurer.

Mrs. Hames presided over the meeting, at which an interesting program was presented, and the work for the coming year was planned.

Picardy gladioli decorated the living and dining rooms and a sandwich plate was served to the members present at the close of the meeting.

The Woman's Auxiliary page is for reading, therefore, I am taking this means to contact the Medical Auxiliary members over the state. Right now with old sol registering over 100 degrees we are not in a receptive mood for work, but with the first cool breezes of fall, I trust, we will go forward with our program.

Mrs. Eben J. Carey, National President, has just sent a letter stressing the new committee, "War Participation Committee," through which committee we hope to write the efforts of our Auxiliary members to function as a group, and not merely as an individual under the sponsorship of another organization. With the next issue of the Bulletin, committee chairmen and county presidents will then be notified of the year's program.

These days of rationing, what woman isn't eager for a new recipe, so I give you my—

OFFICIAL FAMILY CAKE

Break into mixing bowl official eggs, fresh with enthusiasm; beat well with the whip of determination, adding a dash of experience; sweeten with diplomacy; flavor with a heaping measure of humor; add a cupful of the milk of human kindness; to a portion of leadership allow a pinch of initiative; sprinkle with pep, a heaping spoonful of efficiency; sift these ingredients well; to remove all dross of self-interest and personal ambition; shorten with just enough dignity—too much will make it crusty and it will surely fall; stir gradually until you have a smooth mixture of cooperation; carefully avoid making it thin with inconsideration or the cake will be sad; now pour into the pan of loyalty, well greased with happiness; bake in a moderate temperature of sincerity; not too hot with criticism, nor too cool with indifference, but with the oven heat of sympathy and sisterly love. The cake may be frosted with good looks and decorated with fair raiment, avoid figureheads, for they are tasteless. This recipe is palatable if served with only sauce of personality, and garnished with a bit of charm.

County Auxiliary, will you kindly mail to state secretary, Mrs. Harry Murry, Texarkana, a list of new officers. Please watch for the notice of the fall board meeting in Little Rock early in October which will be sent you a month in advance of same. Until then, my kindest regards and best wishes to all,

Sincerely,

NETTIE F. KOSMINSKY, President.

RECENT AMENDMENTS TO FOOD RATIONING MEET NEW NEEDS

Recent amendments to food rationing orders, involving osteopaths, condensed milk, fats, oils and hospitals, are summarized in The Journal of the American Medical Association for July 17 as follows:

The Office of Price Administration announced on July 2 that any medical practitioner authorized by the state in which he practices to prescribe all internal drugs is also authorized to certify that a person requires supplementary food rations for health reasons. Authority to make such certification was previously confined to doctors of medicine. OPA has now broadened the authority so that osteopaths in states which license osteopaths to prescribe all internal drugs may also prescribe supplementary food rations. Food rationing regulations provide that a person whose health requires more rationed food than his ration points permit him to buy may apply to his local board for necessary additional points. In some illnesses foods are prescribed in addition to drugs or medicines, or as a substitute for them. In some counties the work of ration boards in processing such applications has been much simplified through the voluntary help of the doctors themselves. By establishing panels to review all medical certifications and to advise the boards, responsibility for issuing extra rations for health reasons has been kept on a professional level.

The Office of Price Administration under date of June 1 placed evaporated and condensed milk on the list of rationed products. These types of milk are added to the group of rationed foods containing meats and fats, for which red ration stamps are needed, without any increase in the total number of points allowed for this group. One point is required for one 14½ ounce can or for two 6 ounce cans or for two 8 ounce cans. This means that the child may use 7 of his 16 points per week for his milk requirements in terms of evaporated milk, which allows slightly less than the equivalent of a quart of whole milk per day, and have 9 points remaining for his meat and fat requirements. An invalid or any other person whose health requires that he have more canned milk than he can obtain with the stamps in his War Ration Book II may apply at his local War Price and Rationing Board for additional points. The consumer must submit a written statement of a licensed physician showing why he must have more canned milk, the amount needed during the succeeding two months and why unrationed foods cannot be used instead. A supplemental allotment to acquire canned evaporated and condensed milk needed by a hospital to meet the dietary needs of its patients may be obtained on application to its local War Price and Rationing Board. It is understood that, if the present method of rationing does not make evaporated milk available in all areas for infants and children, some more effective method will be worked out.

The Office of Price Administration has issued an amendment to ration order number 16 (R. O. 16, amendment 25) which permits the use of rationed fats and oils for external therapeutic purposes. This includes the use of vegetable oils, such as cottonseed oil, for bathing newborn infants, for external application in skin diseases, for urethral injection or lubrication of urethral instruments, and for X-ray visualization. Such use of rationed fats and oils is defined as "industrial consumption" and persons using these products for such purposes are classified as

"industrial consumers." An industrial consumer engaged in the care and treatment of the sick and needing rationed fats and oils for this purpose may apply to his district Office of Price Administration for a certificate with which to acquire them. The procedure to be followed, briefly, is as follows: The application should be made on form R-1605 to the district office. If the applicant is a hospital the district office will pass on the application by using the same method of computing allowances as the local boards use in computing allotments for industrial users; otherwise the application will be forwarded to the Washington office for action. If the applicant requires more than he would receive by the method of computation described, he should also submit form R-315 stating the reasons for such request. An "industrial consumer" to whom a certificate is issued for "industrial consumption" of rationed fats and oils may use it only to acquire the foods for which application was made and may use those foods only for the purpose for which the application was granted.

For several months the Office of Price Administration and medical authorities have been studying the hospital problem with a view to developing a uniform procedure covering the granting of supplemental allotments for hospitals. Solution of the problem is believed near. In the meantime a provision in the regulations (section 11.6 of general ration order 5) should enable hospitals to obtain the necessary supplemental allotments so that patients need not suffer from dietary deficiency. This provision gives local boards authority to grant such allotments to meet the dietary requirements of patients living in and receiving care in hospitals whether or not such patients are on special diets. In determining the amount of the supplemental allotment of processed foods and the commodities covered by ration order 16, the local board will take into consideration the availability of fresh fruits and vegetables, unrationed substitutions such as poultry and fresh fish, and the physical facilities of hospitals to process and store such foods.

COMMUNIQUE

To the Editor:

Thank you very much for your letter. My present address is as given above. I was at the Naval Air Station at * * * until April of this year and then was transferred to the * * *. Unfortunately we cannot reveal the name of our station. I certainly appreciate receiving The Journal. With best wishes.

Yours truly,

Charles D. Belcher, Jr.,
Lt., M. C., U. S. N. R.

COMMUNIQUE

To the Editor:

Please change my Journal address from Borden General Hospital, Chickasha, Oklahoma, to Ward 4-A, Army and Navy General Hospital, Hot Springs National Park, Arkansas.

I am at present a patient here. I was injured during landing training during the third week of the course at the parachute school, Fort Benning, Georgia, severe contusion to the right

pectoral girdle (shoulder and a-c joint). Now they are observing me for cardiac strain. Don't think it is serious.

Certainly enjoy The Journal and thanks again.

Yours truly,

Miles F. Kelly,
Captain, M. C.

COMMUNIQUE

To the Editor:

Received your request for new address.

Am out in the desert and this 132 degree heat is—well, too good, it ain't, nuf sed!

Capt. Bill Dunaway of Conway is near here, Thermal Air Base, 94th Station Hospital (near—28 miles in near!), in case you do not have his address.

Best regards—I really enjoy The Journal.

Sincerely,

Capt. John J. Monfort, M. C.

COMMUNIQUE

To the Editor:

Awfully sorry to have failed to notify you of the change of address but appreciate the membership card. Would enjoy The Journal if you could forward it to the present address. You would be surprised how one wonders what the old friends are doing back at home.

Yours very truly,

L. T. Taylor, Lt., M. C., U. S. N. R.,
4276 Ibis Street,
San Diego, 3, California.

COMMUNIQUE

To the Editor:

In response to your letter of August 10th, allow me to say that the address is still Turner Field as you will note on the letterhead. It is as hot as blazes down here but I had the good fortune to procure a plane and fly up to Hot Springs for last week-end which I spent enjoyably with my mother. It was certainly hot in Arkansas, I believe even hotter than here.

With kindest regards to you and the hope that you will find time sometime to drop me a card, I remain

Yours,

Berry Bowman,
Captain, Medical Corps,
Station Hospital,
Turner Field, Georgia.

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The Oklahoma City Clinical Society has completed its preparations for the thirteenth annual conference to be held October 18, 19, 20 and 21. In preparing the program this year, special effort has been necessary, and much additional work entailed because of the national emergency. The Society has been able, however, to secure speakers and teachers of unusual ability, and the caliber of the meeting is expected to exceed the excellent conferences of the past. The guest speakers are:

Dr. A. H. Aaron, Professor of Clinical Medicine, University of Buffalo.

Dr. Bilray Papin Blair, Professor Emeritus of Clinical Surgery, and Professor Emeritus of Oral Surgery, Washington University School of Medicine.

Dr. Louis A. Buie, Professor of Surgery, University of Minnesota, Mayo Foundation.

Dr. Leroy A. Calkins, Professor of Obstetrics and Gynecology, University of Kansas School of Medicine.

Dr. Theodore J. Dimitry, Director, Department of Ophthalmology and Professor of Ophthalmology, Louisiana State University; Professor of Special Anatomy, Loyola University.

Col. Franklin G. Ebaugh, Medical Corps, A. U. S., Headquarters Eighth Service Command, Dallas, Texas, on leave for military service from University of Colorado

Medical School as Professor of Psychiatry and Director, Colorado Psychopathic Hospital.

Dr. George B. Eusterman, Professor of Medicine, University of Minnesota, Mayo Foundation.

Dr. Charles Brenton Huggins, Professor of Surgery, University of Chicago.

Dr. Clinton W. Lane, Instructor of Dermatology, Washington University School of Medicine.

Dr. Harry E. Mock, Associate Professor of Surgery, Northwestern University School of Medicine.

Dr. Thomas G. Orr, Professor of Surgery and Head of Department, University of Kansas School of Medicine.

Dr. Louis E. Phaneuf, Professor of Gynecology, Tufts College Medical School.

Dr. Robert D. Schrock, Professor of Orthopedic Surgery, University of Nebraska School of Medicine.

Dr. John A. Toomey, Professor of Clinical Pediatrics and Contagious Diseases, Western Reserve University School of Medicine.

Dr. W. Likely Simpson, Professor of Otolaryngology and Head of Department, University of Tennessee.

Dr. Charles T. Way, Assistant Clinical Professor of Medicine, Western Reserve University School of Medicine.

Dr. J. W. Ames, Vice-President of the American Medical Association, Denver, Colorado.

Symposia presented by local physicians and discussed by guest speakers will continue to be most practical and stimulating.

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to be neglected, and the unique program for the annual smoker promises to be interesting.

Medical meetings of this type will necessarily be curtailed during the war period, and the Clinical Society therefore urges all physicians of the Southwest to avail themselves of these opportunities as they are presented.

The registration fee of \$10.00 includes ALL the general assemblies, roundtable luncheons, dinner meetings, postgraduate courses, and smoker for registrants from outside Oklahoma City. Additional information may be obtained from the Secretary, 512 Medical Arts Building, Oklahoma City.

BOOK REVIEWS

Neurosurgery and Thoracic Surgery: Prepared and edited by the Subcommittees on Neurosurgery and Thoracic Surgery of the Committee on Surgery of the Division of Medical Sciences of the National Research Council. 310 pages. W. B. Saunders Company, 1943.

This is Volume VI of a series developed for the Medical Departments of the Army and Navy. 213 pages are given to five chapters dealing with gunshot and other injuries of the scalp, skull, and brain; gunshot and other injuries of the spinal cord; injuries of intervertebral disks

in military service, injuries of peripheral nerves, and infections of the nervous system and its coverings arising from injuries of war. Methods pertaining to transportation, consideration of shock, early records including first aid cure, preliminary care of the wound, and control of hemorrhage are discussed.

The surgical treatment proper adds nothing in particular to the knowledge of the trained neurological surgeon. In fact, parts of the surgical treatment, particularly that pertaining to the treatment of compound depressed fractures of the skull and that pertaining to suturing peripheral nerves dates back to experiences and publications of many years past. However, for an inexperienced one who finds the problems of surgical care forced upon him in the emergency, or for one whose training because of war is of necessity very brief, this manual would be of help.

The portion of this manual dealing with Thoracic Surgery covers 89 pages. The general principles of thoracic surgery, simple treatment of thoracic injuries and operative surgery are capably discussed in a clear manner, and in satisfactory detail for the space permitted. This portion of the manual will be of help to the military surgeon and the general practitioner as well.

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Dr. Leroy A. Calkins, OBSTETRICS, University of Kansas School of Medicine.

Dr. Theodore J. Dimitry, ORTHOLMOLOGY, Louisiana State University.

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LITTLE ROCK, ARKANSAS, OCTOBER, 1943

No. 5

THE GALL BLADDER PROBLEM *

R. L. SANDERS, M. D.
Memphis

Cholecystitis is the most common disease of the digestive tract. Approximately 30 per cent of all persons over forty-five years of age have symptoms referable to the gallbladder, and approximately half of these will have stones. There is, however, no age limit to the disease. Though the majority of patients are between forty and sixty, individuals of any age may be affected. In a study of 3,000 private cases, we found the youngest patient to be four years of age and the oldest eighty-four. Strikingly, two-thirds of these patients are women. This is in direct reverse of the sex incidence of duodenal ulcer. Of our 3,000 patients, 69 per cent were females and 31 per cent males. Further, cholecystitis seems to have a predilection for blond individuals with a tendency to obesity. We have found the average weight of these patients approximately 145 pounds. Thus, regarding gallbladder sufferers, Deaver's old adage of "Female, fair, fat and forty" holds a good deal of truth.

Symptoms.—Patients with gallbladder disease may be classified into three types: (1) Those who have attacks of gallstone colic, but good digestion between attacks; (2) those who have digestive disturbance but no colic; and (3) those who have both colic and a digestive disorder. One must recognize these three types in order to keep in mind a full picture of the disease.

The most universal symptoms of early cholecystitis are a sense of fullness and distress in the upper abdomen, distention, and eructation of gas after meals. A large number of patients also have qualitative dyspepsia to fats and to onions, apples, cabbage and other foods. Pain is seldom a feature, though a dull ache is often present. Nausea without vomiting, and constipation are not unusual. Many patients also describe nervous phenomena, especially related to heart function.

As the disease process advances, the upper

abdominal distress becomes more acute, nausea increases, constipation is more persistent or alternates with diarrhea, nervous symptoms are exaggerated, and the pain is more intense. Occasionally, the pain will resemble the gnawing, burning sensation of peptic ulcer; again, it may be so low as to simulate the pain of appendicitis, or it may be a seizure typical of angina pectoris. As a rule, the temperature remains normal until the infection becomes acute. An elevation of temperature and associated chills indicates an empyema of the gallbladder.

With these indications of progression of the disease, other less definite signs may appear. The patient may describe vague, generalized symptoms common to toxemia, such as exhaustion, insomnia, dizziness, spots before the eyes, pains or aches in or about the joints and muscles, headaches, a capricious appetite, and a bad taste in the mouth. There will be little or no weight loss unless qualitative food dyspepsia is so pronounced as to prevent the patient from taking an adequate diet.

We have encountered gallbladder colic in approximately 60 per cent of our cases. The attacks are characterized chiefly by sudden pain, which begins in the epigastrium and, as a rule, radiates to the right shoulder. In some cases, however, it radiates to the left, and in others to the right iliac region. The pain is severe in the extreme, causing the patient to toss about ceaselessly in an attempt to obtain relief. Vomiting gives only temporary respite from the intense suffering. The attack may last for only a few minutes, but more often it continues for several hours, then ceases as abruptly as it began.

If the obstruction is incident to infection, the pain will begin more gradually, though it will also become severe and radiating in type. The temperature will rise and remain elevated until the infection subsides. In the majority of cases, the process clears slowly and the symptoms likewise gradually diminish. In others, however, they persist, necessitating prompt surgical interference.

Jaundice may be noticed within a short time after the onset of the attack, and it may or may

* Read before the 68th Annual Session, Arkansas Medical Society, Little Rock, April 19, 1943.

not disappear after the other signs and symptoms have subsided. As a rule, jaundice indicates obstruction of the common or hepatic duct by a stone, and less often by inflammatory edema or some extrinsic factor. In our experience, approximately 20 per cent of patients with cholecystitis give a history of jaundice.

Diagnosis.—Bearing in mind the three symptomatic types of cholecystitis, one may generally make a diagnosis with relatively little difficulty from the clinical history and examination. In acute cases, gentle palpation of the upper abdomen will elicit a mass, tenderness, muscular rigidity and hyperesthesia of the skin over the gallbladder region. In chronic cases, however, palpation often yields negative or insignificant findings. If jaundice is associated and the condition is not acute, a palpable mass in the right epigastrium strongly indicates malignancy of the head of the pancreas or ducts, or a pancreatitis. The liver is often enlarged below the costal margin, especially in the presence of a chronic obstruction or coexisting hepatitis.

The chief diagnostic problem may be the differentiation between cholecystitis and appendicitis, especially since they are so often associated. Right iliac pain is not uncommon in cholecystitis. Conversely, a high-lying diseased appendix may be mistaken for cholecystitis. It is not always possible to make the distinction merely by palpation. One must rely upon other diagnostic methods.

Equal difficulty may be encountered in distinguishing between cholecystitis and peptic ulcer by the symptoms and even by physical examination. Gastric analysis and the roentgenogram should help to clarify this question.

Though one may often make a correct diagnosis by the signs and symptoms alone, no examination for gallbladder disease is complete without the aid of roentgenograms and laboratory studies.

Frequently, a flat plate will demonstrate opaque shadows which will be distinctly recognized as stones. Patients with chronic cholecystitis, however, should have a more thorough roentgenographic study, according to the method of Graham and Cole. This method is designed not only to reveal the presence of stones and new growths, but also to test gallbladder and liver function. A proper interpretation of the cholecystograms is based primarily upon the changes which the shadow undergoes at different periods of the digestive cycle, rather than on the general shape and position of the shadow at any one time. A normal response indicates good liver

function, a patent cystic duct, and a gallbladder capable of adequate absorption, concentration and evacuation. The density of the shadow may range from the darkest, or normal, to one so faint as to be hardly perceptible, according to the extent of the disease and the amount of dysfunction. A faint shadow is evidence that practically no bile is entering the gallbladder, that its absorptive and concentrative function has been almost destroyed, and its evacuatory function is lost. Total absence of a shadow may indicate obstruction of the cystic duct, or liver damage and consequent failure of the liver to eliminate the dye. A competent roentgenologist can usually differentiate between the latter two conditions.

Duodenal drainage is useful in enabling one to distinguish, by microscopic study of the bile obtained, between ordinary catarrhal cholecystitis, calculous cholecystitis, and obstructive cholangitis. The capacity of the gallbladder may also be determined by the amount of the bile. An excessive amount may be interpreted as a sign of an atonic or cystic organ, whereas a diminished amount or total lack of bile will point to obstruction.

The icterus index affords an effective means of detecting and studying jaundice. Repeated tests will show whether the jaundice is deepening or subsiding.

Treatment.—Cholecystitis is recurrent and progressive. By proper dietetic and other measures, the patient may get along fairly well for a time, but gradually the primary disease, with or without stones, is followed by destructive changes in the biliary system, as well as in other organs.

The liver is especially subject to injury in cholecystitis, the parenchyma being first involved. If the causative agent is removed early, regeneration of the diseased portion will take place. With continued onslaught, however, the entire organ may undergo pathologic change. Some years ago, Counseller and his associates did some excellent work in illustrating the varying degrees of damage to the liver architecture as a result of biliary tree infection and obstruction. They showed that a prolonged obstruction of the common duct will produce sufficient back pressure and dilatation of the ducts to distort the liver and give the impression of hydrohepatosis, just as hydronephrosis follows blockage of the ureters. The longer the obstruction persists, the greater the injury to the liver and the less the likelihood of repair.

As to the gallbladder itself, neglect of proper treatment may lead to inflammation and edema of the surrounding tissues and to the formation

of disabling adhesions, while within the walls the process may continue on to gangrene and perforation. The usual site of perforation is posteriorly into the liver substance, where it is protected. Not infrequently, however, it takes place near the cystic duct and is protected by surrounding structures. Rarely, perforation occurs into the free peritoneal cavity.

Finally, there is the possibility of carcinoma. Malignancy is observed in 2 to 4 per cent of all gallbladder affections. It should therefore be borne in mind as a potential development in prolonged cholecystitis. This is especially true when stones are present, as stones are almost universally found in association with carcinoma of the gallbladder or ducts.

These possibilities suggest the advisability of early surgery in cholecystitis. The operation of choice is cholecystectomy. Cholecystostomy, however, is safer in a limited number of cases, i. e., in elderly individuals with complicating disease of other organs, or in the more acute cases wherein there is excessive edema and swelling of the tissues about the ducts, making their identification difficult and dangerous and the risk of cholecystectomy too great.

There are two questions, in particular, which have long occupied and still are occupying the attention of surgeons in dealing with cholecystitis. The first of these concerns the most opportune time for operation in acute cholecystitis. There seems to be no definite agreement as to whether operation should be carried out during the acute attack or whether it should be delayed until the process subsides. The decision must rest on the merits of the individual case. Much depends upon the physical condition of the patient. For the good risk patient, operation may be safely undertaken after a period of preparation of 12 to 24 hours, measures being directed chiefly toward restoring the fluid balance in the tissues. Generally, however, operation may be delayed two, three or four days while treatment is continued; one can usually tell just what course the disease process is going to take after the second or third day from the onset of the attack. If the symptoms remain unchanged or become aggravated, operation is urgent. The clinical signs which we interpret as demanding surgery are sustained pain with a tender mass in the right upper quadrant, abdominal rigidity, a rising leukocyte count, and elevation of temperature. Admittedly, these signs are not always present, but with proper clinical observation and laboratory control, the surgeon can usually determine when operation is necessary. Probably the most

important single sign in making the decision to operate is the presence of a tender mass in the right upper quadrant.

Fortunately, the attack will subside under appropriate treatment in a high percentage of cases, permitting the operation to be carried out at a more advantageous time from the standpoint of both the patient and the surgeon.

Although delay beyond a few days is not necessary in the average case, when the signs are favorable a more thorough preparation is advisable for patients who are in poor condition. When jaundice is present, special measures, including the administration of vitamin K, glucose infusions and blood transfusions should be carried out. An estimation of the prothrombin is of value in determining the bleeding time.

The second problem, with which the surgeon is confronted at every operation for cholecystitis, has to do with the desirability of opening the ducts. The present day criteria for choledochotomy may be enumerated as follows:

- (1) Palpation of a stone in the ducts.
- (2) Abnormal dilatation of the ducts.
- (3) Contraction of the gallbladder. A contracted gallbladder is strong evidence of stones in the ducts. There may or may not be stones in the gallbladder as well; we have all seen cases in which stones were found in the ducts, but none in the gallbladder.
- (4) Jaundice or a history of jaundice, associated with gallstone colic. It should be remembered that a stone may also be present without jaundice.
- (5) Dark bile in the duct. In a definitely infected gallbladder, the ducts should be investigated for stone whether other indications are found or not. It is our practice to aspirate a small quantity of the contents of the common duct. If the bile is cloudy and flocculent, the duct is opened, explored and drained. A stone or stones may be found at the lower end of the duct.

We feel that the ducts should not be opened unless the indications are clear cut. In our experience, such indications do not present themselves in more than 25 per cent of cases, and in only about half of these will a stone be found.

Another feature of the treatment of the common duct when obstruction is encountered is the dilatation of the sphincter of Oddi in conjunction with choledochotomy. The operation is not complete until one has determined the patency of the distal end of the duct. Continued obstruction at the ampulla will tend to a recurrence of the disease and further stone formation. By using

graduated bougies, one may dilate the sphincter to almost normal size without injury. Subsequent contraction of the ampulla should not develop.

The success of the operative procedure is also involved to some extent with questions of technic. One of the most important factors for the safety of the patient, and certainly the greatest aid to the surgeon is the proper exposure of the operative field. In the majority of cases, an upper right rectus incision, its middle over the common duct, is suitable. When exposure is adequate, relaxation may be more complete, the ducts and vessels better visualized, trauma and hemorrhage minimized and the technical procedure facilitated.

For the past several years, we have also used the supraumbilical transverse incision extensively in operations on the gallbladder, particularly in obese patients whose abdominal tissues are friable. In such individuals, this approach offers a safeguard against wound disruption and postoperative hernia, and thus materially influences the morbidity and mortality.

Still another problem is that of drainage. The necessity for drainage in the presence of infection is well understood. In other cases, whether to drain or close the abdomen tight after cholecystectomy is more or less contingent on the finding of accessory bile ducts, and whether or not the operative field can be made perfectly dry. We have closed the abdomen without drainage following cholecystectomy in approximately 500 cases. No untoward symptoms have developed, and no evidence of bile leakage has been observed. We are now, however, closing increasingly fewer cases without drainage. Simple drain tubes are brought out through a stab wound, to be removed in four or five days. Also, when the common duct is opened, a T-tube is inserted and left in situ for ten days to several months, depending upon the nature of the condition.

End Results.—The first question which the patients asks when faced with the necessity for operation is, "Will I be relieved of my trouble?" In a follow up study of a large number of our patients, it was found that more than 80 per cent were relieved of their symptoms and an additional 10 per cent were improved. The remainder were not benefited. In a further investigation of those who were not benefited, it was discovered that most of them should not have been operated on at all. With added experience, patients are more carefully selected for operation and a larger number are being improved.

It is significant that the vast majority of patients who are completely relieved are found to

have gallbladder or duct stones, or both. This does not mean that those without stones are not relieved, but it does mean that cholecystitis with stones is more amenable to surgical treatment, particularly cholecystectomy.

Summary

1. Cholecystitis is a progressive and recurrent disease of middle age, and is far more prevalent in women than in men.

2. The symptoms may be classified into three types: (1) Those who have attacks of gallstone colic but have good digestion between attacks; (2) those who have digestive disturbances but no colic, and (3) those who have both colic and a digestive disorder. Bearing in mind these three symptomatic types, one may generally make a diagnosis with relatively little difficulty from the clinical history and physical examination. Laboratory studies and the roentgenogram, however, are valuable aids in confirming the diagnosis.

3. In view of the progressive nature of the disease and the gradual involvement of the ducts and other organs, particularly the liver, early operation is advisable. In the gallbladder itself, the process may lead to empyema or gangrene and perforation, or to other serious developments, if not interrupted early. The presence of stones constitutes an added danger.

4. The treatment of acute cholecystitis is an individual equation. If the operation is carried out at the opportune time, the risk is but little greater in acute cholecystitis than in the chronic case. Jaundice and associated disease increase the risk and call for special preoperative and postoperative care.

5. In many cases, the operation depends to a large extent upon a careful exploration of the common duct. The criteria for exploration of the ducts are fairly well established. They will be present in at least 25 per cent of the ducts, though in only 12 to 15 per cent will stones be found.

6. The operation of choledochotomy is not complete without dilatation of the distal end of the duct. Continued obstruction at the ampulla will tend to recurrence of the disease and further stone formation.

7. An important factor in the success of the operation is the incision. We have found the vertical incision advantageous in the majority of cases, though the supraumbilical transverse incision is preferable in obese patients. In such individuals, the abdominal wall tissues are friable, and the transverse incision tends to prevent wound disruption and postoperative hernia.

8. If the wound can be made clean and dry, the abdomen may be closed without drainage. In most cases, however, a small rubber drain should be brought out through a stab wound to the side. When choledochotomy is performed, a fairly prolonged drainage through the T tube is advisable.

9. The operation of choice is cholecystectomy, in that it obviates the danger of recurrence of the disease and at the same time permits a more rapid convalescence. Cholecystectomy, however, is indicated in a few cases wherein the risk of the more radical operation is too great.

10. In properly selected cases, approximately 90 per cent of the patients will be benefited by cholecystectomy. This applies not only to those with stones in the gallbladder and those with cholesterosis, but also to those who have a badly diseased noncalculous gallbladder.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

"THERE is great satisfaction to the physician, and great benefit to the community, in having made an early diagnosis and instituted treatment in case of tuberculosis, and having perhaps found a second case among the family contacts." So says Dr. Sartwell in his thoughtful article discussing the opportunity confronting the private practitioner as a result of the growingly popular mass chest X-ray surveys of American men and women. The danger inherent in purely roentgenographic diagnosis is stressed, but primary emphasis is rightly laid upon the painstaking follow-up and supervision the family doctor owes to every patient about whose lungs the X-ray has raised even a suggestion of doubt.

THE FAMILY PHYSICIAN HOLDS THE ACE CARD

Increasingly, family physicians may expect to see numbers of men and women who have been told that they have tuberculosis and referred to their own doctors for advice, treatment and further study.

These cases are the product of widespread and ambitious programs of mass chest X-raying in Army and Navy inductions, in industrial plants, in colleges and among other groups. In Massachusetts the Army alone has rejected for military service more than 2,000 men because of actual or suspected pulmonary tuberculosis.

A system has been set up in Massachusetts that works very well and that has its counterpart, with various modifications, in many areas of the United States. The names and addresses of rejectees are forwarded from the examining station to the Department of Public Health. The state district health officer, working through the local board of health, pursues a follow-up that attempts to secure answers to important questions on each such rejectee.

Has the patient been X-rayed again? If so, by whom? What were the findings? Was the diagnosis of tuberculosis confirmed? If so, has the case been reported? What further study or treatment has been recommended, and is it being carried out? If the diagnosis was confirmed, how many household contacts have been

X-rayed and what are the names of any found to have tuberculosis?

In the case of industrial surveys, with the patient's cooperation a roentgenographic report is sent by the Department of Public Health to the designated family physician. Only in instances where the patient says he has no regular physician or does not intend to consult one is attendance at a tuberculosis clinic suggested as an alternative to private care.

Cases reaching the doctor through these channels of reference fall into several groups:

1. **Active tuberculosis:** This is the simplest, perhaps, as these people need prompt sanatorium care, possibly collapse therapy as well. Repetition of the X-ray may be unnecessary, if the diagnosis is clear-cut. Three necessary steps include: reporting the case, arranging for admission to a sanatorium and examining by X-ray all household contacts. It should be emphasized, however, that diagnosing and reporting tuberculosis solely on the basis of X-ray evidence can result in serious errors.

2. **Suspected tuberculosis:** In the light of an X-ray opinion this usually means that the roentgenologist has seen a small hazy or infiltrative shadow but is not sure enough of its presence or significance to label it pulmonary tuberculosis. Invariably these patients need another film. Im-

proved technic may be sufficient to settle the question. Disappearance of the suspicious lesion may indicate it was of acute pneumonitic origin. Generally, however, this new film—since the original is rarely available—becomes the first of a progress series by means of which a suspicious area is to be observed. Symptoms and physical signs are more likely to be lacking than elicited in such early cases. Exhaustive clinical and laboratory study is indicated. While a sputum or gastric sediment containing tubercle bacilli is sometimes found and is clinching evidence of tuberculosis when confirmed by culture or animal inoculation, such things as a shift in the differential leukocyte count, accelerated red blood cell sedimentation rate and slight rise in temperature late in the day are of confirmatory value only, as they are not specific for tuberculosis, nor is their absence proof that a lesion is either non-tuberculous or inactive. Most valuable aid in following and evaluating all such cases is the procedure of serial X-ray filming at appropriate intervals.

3. Inactive or healed tuberculosis: Most of the measures advocated for Group 2 above apply with equal force to this third category. An initial film is always advisable and full study and periodic filming is essential whenever there is the slightest doubt about the true status of the lesion, especially in young subjects or where a lesion is beyond the minimal limits. It should be recalled that the classification of minimal, moderately advanced or far advanced refers solely to the extent of the involvement, not to the activity of the process. Physicians should acquaint themselves with the groupings of patients according to clinical status as set forth in "Diagnostic Standards," published by the National Tuberculosis Association. However, it must be realized that no such exact classification as apparently cured, arrested, apparently arrested, inactive and active can or should be attempted from examination of a single X-ray film. Even to try to grade cases as active or inactive on such a basis leads to many errors, although the visualization of cavities allows no question that activity is present.

4. Primary phase tuberculosis: This diagnosis is commonly but clinically not important in adults. Rarely is it active, usually being of the calcified primary complex type. Nevertheless, it is essential that the physician make certain his case is clearly in this category before so dismissing it.

5. Pleurisy with effusion: This is rarely discovered in mass surveys. Evidence of old attacks

commonly shows up, but means little if none has occurred within five years.

6. Non-tuberculous conditions: These are fairly frequently encountered. A few may be mistaken for tuberculosis, but careful study will usually reveal the true nature of shadows caused by such conditions as a typical pneumonia, bronchiectasis, atelectasis, suppurative lung abscess, lymphoma, sarcoid, cystic disease of the lung and primary or metastatic lung cancer. Emphysema, generalized pulmonary fibrosis and spontaneous pneumothorax should not be too difficult of recognition. Abnormal cardiac silhouettes often give the clue to unsuspected heart lesions, while developmental anomalies of visceral or skeletal nature are of passing interest.

* * * *

It should be remembered that tuberculosis is a disease of adults and is seldom found in children after infancy and before adolescence; that its prevalence tends to increase with age from adolescence on; that the frequency of inactive disease also increases with age; that the majority of reinfection-type lesions found in young persons are unstable; and that many lesions in older persons are a greater source of danger to their associates than to themselves.

It is highly important that private practitioners make the early diagnosis that confers greatest benefit on the patient, his family and the community. Unfortunately, sanatorium records show that the proportion of far-advanced cases admitted for the first time has not yet declined, nor has the proportion of minimal cases risen, in spite of the wider use of X-ray. Surveys cannot reach everyone; the public must be educated to consult a physician earlier, and the physician must be on the alert.

New case-finding methods have initiated a large scale attack on unsuspected tuberculosis among apparently healthy people. It is the duty as well as the opportunity of the family physician to carry it through.

Roentgenographic Surveys for Tuberculosis in Massachusetts and Their Importance to the Physician, Philip E. Sartwell, M. D., New England Journal of Medicine, June 3, 1943.

COMMUNIQUE

To the Editor:

I look forward to my issues of The Journal and I appreciate your efforts to complete delivery.

Lt. Harold M. Armstrong, M. C.

THE JOURNAL

OF THE

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EDITORIALS

OBSTETRIC AND PEDIATRIC CARE PROGRAM FOR WIVES AND INFANTS OF ENLISTED MEN

Based upon experience obtained through operation of the Federal plan to provide obstetric and pediatric care to the wives and infants of enlisted men during the past months, the Council has withdrawn its approval of the program. A number of factors were involved in this decision. It was felt from the inception of the program that it was unsound in principle. Nevertheless, efforts were made to effect a more practicable working plan for Arkansas but these failed to meet the approval of the Federal agency.

Some of the objections raised to the program are that it provided assistance irrespective of need; that it did not provide unrestricted choice of physician; that it established a medical program under control of the Federal government;

that it precluded assistance on the part of relatives or friends of the families of servicemen; that it excluded the assistance of voluntary relief and welfare agencies; that it established a mandatory, inelastic maximum fee schedule for professional fees, regardless of the merits of individual cases or of medical care problems involved; that it placed a third party in to the relationship of physician and patient, and that it established a base for a much larger Federally controlled medical care program.

The Society has not been advised of any action to be taken by the Children's Bureau, Department of Labor, the sponsoring agency, or by the Arkansas State Board of Health, the administrative agency.

U. S. CADET NURSES CORPS

As a measure to provide additional trained nurses for war and civilian needs, Congress passed the Bolton Act June 15th. Under this act, governmental payments are made to co-operating hospitals providing for tuition, stipends, maintenance, fees and uniforms for nurses in training. Any student nurse who has been in training since January 1st, 1941, is also eligible to join the corps. The prospective trainee may choose any hospital which has concluded an agreement with the Federal government for the program.

It has been estimated that over 60,000 new student nurses are now needed. Drafted with full cooperation of hospitals, nurses associations and governmental agencies, the act seeks to solve this problem. The method whereby medical students are now receiving free training has thus been extended to nurses. It is contemplated that the course in training for nurses will be shortened to between 24 and 30 months. Payments of from \$15.00 to \$30.00 per month will be paid to trainees, who will receive, in addition, maintenance and uniforms. Hospitals which had adopted the plan as of that date were listed in the March 27th, 1943, issue of The Journal of the American Medical Association.

EDITORIAL COMMENT

DID YOU WRITE A LETTER?

WRITE A LETTER *

The Journal is pleased to publish in this issue a number of letters from our members now with the armed forces. All agree that news from home is most welcome. It seems that those of us at

home owe them a short newsy letter at frequent intervals. Because of censorship requirements, The Journal is not permitted to publish the addresses of those members who are in service overseas but letters to these physicians sent in care of The Journal will be promptly forwarded.

Altogether now, give the editor "writer's cramp" from re-addressing all these letters.

* Reprinted from September issue.

DR. PELOUZE TO VISIT STATE

County and district medical societies are advised that Dr. S. P. Pelouze, noted authority on gonorrhea, will visit Arkansas in the period March 13th-24th, 1944, under sponsorship of the United States Public Health Service. Insofar as engagements permit, Dr. Pelouze will be in a position to address county and district medical societies in the state during his stay. Societies wishing him to appear on programs should make inquiry of the Arkansas State Board of Health.

COMMUNIQUE

To the Editor:

I received your letter sometime ago requesting notification of changes of address. Since mine has not changed for the past sixteen months and I have been receiving The Journal regularly, I have been negligent in replying. My delay in writing is in no way a measure of the pleasure I get out of reading The Journal. I look forward to its coming each month. I not only enjoy the scientific articles, but through it, I am able to keep up with the whereabouts of many of my friends and former students and also, the activities of those of you at home.

I thoroughly enjoyed your "Random Thots" of August 26. Looking for more.

I am glad to see your activity in regard to the proposed legislation affecting medical practice. I trust that every member of the Society will do all in their power to see that no bill is passed that will tend to lower the standards of medical service in this country.

This is an excellent hospital and the staff is composed of a very fine group of men but I am looking forward to the time, I hope not too distant, when I can return to Good Old Arkansas.

Sincerely,

Joe H. Sanderlin
Lt. Col. M. C.

William Beaumont
General Hospital
El Paso, Texas

PROCEEDINGS OF SOCIETIES

The Benton County Medical Society met in dinner session at Cave Springs September 9th as guests of E. J. Highfill. Discussion of the Wagner bill was the program.

Geo. M. Love, Secretary.

The Lawrence County Medical Society was addressed at its August meeting by J. C. Land, "Bronchitis," and Chas. D. Tibbels "Bronchiectasis."

The Tenth Councilor District Medical Society met in dinner session at Fort Smith September with Mr. R. H. Graham, Secretary, the Oklahoma State Medical Association, discussing voluntary prepaid medical care plans. Officers elected are: R. H. Huntington, Fayetteville, President; A. A. Blair, Fort Smith, Vice-president, and Ralph E. Crigler, Fort Smith, Secretary-Treasurer. The Society will next meet in Fort Smith.

Chas. T. Chamberlain, Secretary.

The Southeast Arkansas Medical Society met at the Japanese Relocation Center near Dermott, September 13th, guests of Dr. J. L. McSparran, Chief of Staff of the Japanese Hospital. Sixty-six physicians and guests were present. After dinner was served, the Auxiliary was entertained by Mrs. McSparran and the following program was presented:

Dr. Melvin W. Hunter, Monroe, La., "Coronary Occlusion."

Dr. James Edwin Walsworth, Monroe, "Appendicitis."

Japanese doctors of the medical staff presented an excellent thesis on Carcinoma of the Small Intestine, illustrated by x-ray and pathological specimens.

S. W. Douglas.

COMMUNIQUE

To the Editor:

I am hoping the weather there is not as hot as it is here at present.

Enjoy getting The Journal very much. It makes one feel that he is not completely lost from the state and county medical men.

Best regards,
Capt. Richard W. Miller, M. C.
222nd General Hospital
Fort Leonard Wood, Missouri

PERSONALS AND NEWS ITEMS

Gilbert L. Kimball, DeQueen, now on duty at Camp Wolters, Texas, has been promoted to captain.

Hugh Johnson, Fort Smith, spent a recent vacation in Hot Springs National Park.

H. E. Murry has been elected president of the staff of Michael Meagher Hospital at Texarkana.

Dr. and Mrs. S. J. Wolferman and Dr. E. C. Moulton, Fort Smith, spent a September vacation at Crede, Colorado.

Gerald Blankfort, Little Rock, now on duty at Jefferson Barracks, Missouri, has passed examinations as a Diplomat of the American Board of Internal Medicine.

Lt. Art B. Martin, Fort Smith, has completed a course at Carlisle Barracks.

L. J. Kosminsky, Texarkana, has been appointed child welfare chairman for the American Legion, Department of Arkansas.

I. F. Jones, Fort Smith, recently took special work in Philadelphia.

Lt. Harold M. Armstrong, Little Rock, is now stationed overseas.

John C. Faris, Jonesboro, now stationed at San Antonio, has been promoted to captain.

Lt. Guy Shrigley, Clarksville, is now stationed with the 195th Station Hospital, Fort Ord, California.

Lt. Milton C. John, Jr., Stuttgart, is now serving overseas as a flight surgeon.

Capt. Wylie E. Turner, Jr., Piggott, is now on duty at Billings General Hospital, Fort Benjamin Harrison, Indiana.

Capt. Merl T. Crow, Warren, is now serving overseas.

Capt. Robert L. Turnbow, Little Rock, is now serving overseas.

Lt. Jack M. Sheppard, El Dorado, is now stationed at Wendover, Utah, with the air forces.

Lt. John E. Greutter, Little Rock, is on duty with a general hospital overseas.

Chas. P. Wickard, Little Rock, has been promoted to captain.

BORN—On August 26th, a daughter, to Dr. and Mrs. R. J. B. Hibbard, State Sanatorium.

James Q. Blackwood, Helena, now on duty at Seymour Johnson Field, N. C., has been promoted to captain.

Capt. Joe Verser, Harrisburg, is now in service overseas.

James W. Amis, Fort Smith, now on duty overseas, has been promoted to commander.

Lt. C. C. Reed, Jr., Little Rock, is now in service overseas.

L. N. Bollmeier has returned to Hot Springs National Park where he will confine his practice to psychoanalysis, psychiatry and psychosomatic medicine.

F. Q. Wyatt, Batesville, recently took special work in obstetrics in Philadelphia.

B. L. Church, North Little Rock, recently took special work in Chicago.

W. A. Grimmett has been elected commander of the Blytheville American Legion post.

Julius H. Hellums, Dumas, now stationed overseas, has been promoted to major.

COMMUNIQUE

To the Editor:

Just got your notice re The Journal and hastily answer to get my copies coming regularly.

I was fortunate enough last month to find out where Calcote was stationed and spent a very pleasant week-end with him and Joe B. Wharton from El Dorado.

Censorship will not permit a very detailed letter so will save the tales and exaggerations for the first meeting I attend.

It can't be too soon for any of us.

Yours truly,

John S. Agar

RANDOM THOUGHTS OF THE SECRETARY

August 26th. Our condolences to Byron Bennett, Jimmie Lewis, Joe Wharton and others who had to leave before Eleanor arrived and so missed this bit of morale raising.

August 27th. Discussing the medical care problems of Helena and Phillips County and readily disposing of the situation for the time being, affording the opportunity to call on Pete Deisch who suggests the desirability of our taking steps to avoid the succession of accidents which have befallen us, and if this can be done, it meets with our full approval. To Forrest City with Rush where we visit him until bus time with pleasant reminiscences, bringing forth the fact that he once sold medical books and that he now has one of the finest individual collections of Indian pottery, etc., that we have seen. To Memphis standing in the bus aisle, waiting in the cool Peabody lobby and thence away on the Rocket, completing a full 24 hours at Booneville with sleep only in the stretch yesterday morning Little Rock to Memphis but that was the best two hours we ever put in with the Pullman Company.

September 6th. This being Labor Day, we concern ourselves with the following tasks: the effort to bring order out of chaos in the procurement and assignment files; with arranging the agenda for the coming Council meeting, and with the estimation of our 1943 income tax, and what may have been a holiday somewhere is of academic interest only to us.

September 7th. By rail and bus to Pine Bluff this afternoon watching the boom-town street traffic and knowing that the permanent residents would gladly give it all up for a normal main street traffic, crowded only after Zebra football games. So to the newly-constructed hospital, which obtained priorities by some supernatural process, and to talk of the distribution of physicians and the like with Lowe, McMullen, Walker and Simmons, articulate for the local profession. Thence availing ourselves of the kindly hospitality of the Lucks junior for a ride to Little Rock, the good doctor and wife intent on a good steak, which we hope was obtained in good measure, but with us thinking ahead of the ride to Booneville and then a drive home with much to be done on the morrow.

September 9th. Just to speculate over Clyde McNeil seeking the post as house physician for the projected nudist camp near Rogers.

September 12th. This day in Little Rock where there is deliberation on procurement and by the Council until we miss our afternoon train by thirty minutes. Irrked at governmental tendencies and demands, approval is withdrawn for the obstetric and pediatric program for the families of enlisted men, yet another Federally-sponsored program, having an enthusiastic speaker present, survives. Lengthy discussion over the Wagner bill brings forth the well-known fact that the individual physician can do more in this fight than can any organization or group. The disturbing question is: "Will He?" Shortly visiting Shuffield working away at his office late this Sunday afternoon and then to see the McNeils, agog with luxury atop a downtown office building, where one reaches the penthouse after a claustrophobic ride in a tiny elevator. Then aboard the Rocket for the 14th or 15th time this year dozing into Booneville where some day we are going to phone Paul McConnell and make an effort at conversation with him at 1:30 A. M.

September 14th. Selling War Bonds these days and meeting with success but wonder just what those boys at Salerno would think of the fellow who told us today that he gave up a golf game to work at selling War Bonds.

September 20th. Comes Dick Graham from Oklahoma way to talk to the 10th Councilor meeting about Blue Cross and the like, interesting in great degree for the knowledge of what a neighboring state society is doing in the way of post-war planning. Obligated to us is this state secretary because of the four hours we spent awake this morning meeting his train aboard which he was not, this lapse of memory being publicly acknowledged by him and, for once, a slip in arrangements is not charged to us.

OBITUARY

CHEVES BEVILL, age 94, died at his home in Waldron, August 28th. Born in Alabama in 1849, he had lived in Waldron since he was 30 years old. Widely known as a naturalist, he had served several years in the state geology department; was the author of a number of scientific treatises; served many years as a member of the State Board of Health; was a former mayor of Waldron and a member of the state legislature. He was an honorary member of the Arkansas Medical Society. Surviving relatives are four sons, one of whom, Dr. S. D. Bevill, is in practice at Poteau, Oklahoma, and five daughters.

NOBLE JACKSON HILL, age 74 years, Hinds-ville, died September 1st after a prolonged illness. Born in Georgia, April 25, 1869, he had spent practically all his life in Madison County, Arkansas. He was married to Miss Mary E. Sharp July 14, 1889, who, with two sons, survives him. At the time of his death he was president of the Madison County Medical Society.

JOHN A. MOORE, age 70, El Dorado, died suddenly September 9th. Born near Three Creeks on May 9, 1873, he graduated from Memphis Hospital Medical College in 1898 and practiced at Lisbon until moving to El Dorado in 1912. On June 3, 1900, he was married to Miss Daisy May Graham, of Lisbon. Dr. Moore was a member of the Board of Deacons of the First Baptist Church, of El Dorado Masonic bodies, of the Union County Medical Society, the Arkansas Medical Society and of the Southern Medical Association, a Fellow of the American Medical Association, and, at the time of his death, was first vice president of the Mid-South Medical Association. Surviving relatives are his wife, one daughter, and one son, Dr. Berry L. Moore, who was associated with his father in practice at El Dorado.

WOMAN'S AUXILIARY NEWS

Members of the Hot Spring County Medical Society and Auxiliary were guests of Dr. and Mrs. Raymond McCray, August 6, at the regular monthly dinner meeting of the two organizations. Pink roses in a crystal bowl centered the dining table with its appointments of delicate china, crystal and silver laid on an imported linen cloth.

Guests included Dr. and Mrs. W. F. Barrier, Dr. and Mrs. W. G. Hodges, Dr. and Mrs. M. D. Prickett, Dr. and Mrs. H. L. Brown, Mrs. R. Y. Phillips and Mrs. E. T. Bramlitt.

The two organizations went into separate business sessions following the dinner.

KANSAS CITY SOUTHWEST CLINICAL SOCIETY'S TWENTY-FIRST ANNUAL FALL CLINICAL CONFERENCE

The Kansas City Southwest Clinical Society will hold its Twenty-first Annual Fall Clinical Conference in the Municipal Auditorium, Kansas City, Missouri, on October 4, 5, 6, 1943.

Round Table Discussions featuring future scientific and medical problems are two new features of the program this year. Five Refresher Courses will be held on each Tuesday and Wednesday morning, each covering practical subjects.

The general assemblies will be presented by the following guest speakers: Dr. Harrison Flippin, Philadelphia; Dr. Chas. Gordon Heyd, New York City; Drs. Frank H. Lahey and Paul D. White, Boston; Dr. Wm. F. Mengert, Iowa City; Dr. Edw. H. Ryneerson, Rochester, Minn.; Dr. Tom D. Spies, Birmingham and Dr. Cyrus C. Sturgis, Ann Arbor.

The Monday evening program will be entirely Military. Discounting exigencies of war, the speakers for this program will be two high ranking medical officers who will bring us first hand information from the front. If you have not received your July-August issue of the Kansas City Medical Journal, which carries an announcement of the entire program of the conference, write the executive office—208 Shukert Bldg., Kansas City, 6, Mo., and a copy will be mailed you at once.

COMMUNIQUE

To the Editor:

*** Believe as many others of the doctors who are now in the army that we do not want to work for the government after this mess is cleaned up. Keep plugging at that end!

Capt. Charles L. Weber

COMMUNIQUE

To the Editor:

I was delighted to receive your letter of August 16th. The last address I have from Bieri is *** I understand that he is somewhere in the vicinity of Fount Richardson.

I have been at the same station for fifteen months as Chief of Medical Service in this hospital of *** beds. As you know, Clyde Rogers is here with me. I am now sweating out an appointment to the School of Aviation Medicine. I expect to go around the first of September, but do not know for sure. I naturally am going to try to make the Southern Medical Association.

I sure would like to see all the boys but from what I hear about the home front, I am glad that I am in the army. I am inclosing a poem that a sea-faring gob wrote about my native state of Texas. This gob was stationed at Corpus Christi and they had to give him a marine guard to keep him from being cut into small pieces.

With all good wishes and kind regards.

Sincerely,

Euclid M. Smith, Major, M. C.
Station Hospital,
Ellington Field, Texas

COMMUNIQUE

To the Editor:

A few days ago I received your bulletin of June 22nd requesting address. Am glad to supply same and tell you that I have enjoyed very much the two copies of The Journal that I have received in the past six months. I guess the other copies were lost in the mails. Air mail letters get out to us rather promptly, considering the distance, usually 2 or 3 weeks. V-mail is about the same. Second class mail is very slow and uncertain, though.

We are now allowed to say that we have been in ***. The people treated all of us splendidly and we admire them for their hospitality and kindness to us, as well as for the valor of their soldiers. ***

We are now on a tropical island. Neil Compton is stationed near here and we have had several good visits. Joe Wharton is not far from here and I hope to see him one of these days. *** We have a fine group of doctors in our medical company. ***

Best regards,

Jim Lewis

Lt. (jg) M. C. U. S. N. R.

COMMUNIQUE

To the Editor:

I received your letter this morning and just in case the camera does not get it all in on the above I will give you my address again down here so you will be sure to get it. (****)

I received the June issue of The Journal about the middle of the month and enjoyed it very much. I think that your idea of getting the latest address is a good one instead of having that interesting bit of news and knowledge follow us around by Laura's.

I haven't seen any fellow members of the Arkansas Medical Society since I have been over here but did run into one once in a while in my travelings back in the States. Or, maybe I should say my former fellow members of the Arkansas Medical Society for so far I have not received my membership card this year. I hope that does not mean that I will have to reapply to the dear old Hempstead County Medical Society for re-admission to the clan when I get back. Would almost rather have the wife send you a check for the dues for the current year than to have that happen. What difference does it make anyway? You can't spend money anywhere over here but in *** and it is not every day that we get off to run down there.

Faternally,

Capt. Jim McKenzie, M. C.

COMMUNIQUE

To the Editor:

I received your letters of August 25th and 27th, the former a few days ago and the latter, today. I'm very sorry you have had so much trouble getting The Journal of the Arkansas Medical Society to me due to the frequent changes of address. However, I have received several of them, three or four while in North Africa, and enjoyed them all. Thanks a lot.

I also enjoyed the "Random Thoughts" received today. I'd like very much to stay on the mailing list and will try to keep you informed of any change of address.

I have not had the pleasure of meeting many of the members of the Arkansas Medical Society but hope to do so when I get back to Piggott.

Sincerely,

W. E. Turner, Jr., Capt., M. C.
Billings General Hospital,
W. 1100
Fort Benjamin Harrison, Ind.

COMMUNIQUE

To the Editor:

Have just received your letter of June 22. The APO's change frequently for us, since we are normally a very fluid unit, serving here and there. Will try to keep you posted on the changes. Am very happy to say that The Journal has been coming through fine in spite of the fact that some of them travel all over ****, and that is exactly what I have been doing too. Believe me the Chicago fire had nothing on some of the places I have seen most recently. My, my, what a little drop of dynamite can do when properly placed!

Hope to make it home in time for our next state meeting.

Thanks a lot and best regards to all.

Ellery C. Gay, Major, M. C.

COMMUNIQUE

To the Editor:

In order that I may receive my copy of the Arkansas Medical Journal, I am asking you to change my address from U. S. Naval Hospital, Corpus Christi to ****. I arrived here on the 12th preparatory to embarking for duty overseas. That leaves only Joe Bounds to uphold the traditions of the Arkansas unit at Corpus.

I am hoping to meet up with Calcote, Wharton, Agar, Jim Lewis, Foltz, Amis, Stocker or some of the rest of the boys in my travels.

Sincerely,

Fred H. Krock

COMMUNIQUE

To the Editor:

Very glad to receive your bulletin. I have been receiving The Journal although many weeks late because of so many changes of station. I have really enjoyed each issue, especially since I get news of my friends and where they are. It is very hard to keep in touch with them after more than two years of army service.

I have been stationed from California to Washington, including four months maneuvers in the California desert. I will be glad to get back to Arkansas when this is over.

Yours truly,
Capt. Doyle L. Patton, M. C.
B. D. Center
Chestnut and Jones
San Francisco, California

COMMUNIQUE

To the Editor:

Your job might be compared to that of an army chaplain, as it seems to be your lot to listen or read all the complaints and infelicities of the members of the profession from Arkansas. I have written you a couple of times because it is satisfying to have some connection with the profession that we all love and cherish. However, you will recall I wrote you last February and called attention to the rising tide of enthusiasm and support that was prevalent around Washington for a government-controlled system for the medical profession. Now we have the Wagner-Murray-Dingell bill which is perhaps the climax to all of that talk.

I mentioned in my letter that the men in the military service could not do much about this condition or threat because of the pressing demands that must be met now in order to get the war over. I also realize that the men who are left at home are very busy trying to meet civilian needs, but I get a very severe attack of nausea when I realize what is about to happen to American medicine. People in all walks of life have the feeling that doctors have lived the life of a king through the ages, that they are rolling in wealth and that the time has come to clamp down on them. The opportunists, as they did with prohibition in the last war, now find a large segment

of the doctors in military service, and believe me, we are about to become the victims of a large scale seduction.

I don't know how extensive the program is to fight this Wagner bill, but I sincerely hope a well-organized defense has been planned. Please keep us informed of developments at home and let us know if and when we can help to fight the sabotage that is being born in the minds of self-ambitious politicians.

Incidentally, I have a new son at Sparks. Please look him over and see if he has the makings of a doctor.

Very truly yours,

Capt. O. B. Barger

COMMUNIQUE

To the Editor:

I have just received your letter concerning The Journal of the Arkansas Medical Society. For your information, it has been almost impossible to receive any copies of periodicals. Although I am anxious to see The Journal, I rather believe it would be a waste to send it on. We have been moving about so frequently and have many changes of address.

However, my address is below. Thanks for your efforts.

Sincerely,

George R. Steinkamp, Capt., M. C.

Keep 'Em Flying

Keep 'Em Floating

Keep 'Em Rolling!



BUY WAR BONDS AND STAMPS

COMMUNIQUE

To the Editor:

Doing fine. Hot here. Busy. Three train loads of prisoners from *** last Sunday and now busy getting straight. Sorry I missed you the night I was in Chaffee.

Regards,

L. D. Massey, Major, M. C.

COMMUNIQUE

To the Editor:

After six months abroad we have finally gotten our teeth in. Except for a brief period in the field we have been tagging around after the heavy bombers, sewing, patching, and stamping on the embers of malaria which forever seem to be cropping up here and there. Mostly grind and monotony — particularly the food — also fleas, flies, and the damned sun which by noonday seems to be funneled through an enormous reading glass directly on the crown of every head. Foolishly, I got a crew hair cut—now my cortex is more than ordinarily addled in our local solar fireless cooker.

I have your recent letter regarding the Journal. Don't send it. Most of the things in it

wouldn't get through. Better still, send it to Martha at Fayetteville.

Give my love to all—my especial regards to your spouse and to Wm. Riley.

As ever,

Ralph Weddington, Lt., M. C.

COMMUNIQUE

To the Editor:

I received your request the other day for my change of address so I thought I would be so kind as to answer and at the same time inform you that I have been receiving The Journal and enjoying it very much. I have been in the *** area for approximately six months and have received five copies.

Please accept my apologies and best regards.

Thos. G. Price

Lt. (MC), USNR

COMMUNIQUE

To the Editor:

I hardly know just how to advise you insofar as my address is concerned. Right now I am doing neurosurgery here at Bushnell General but have orders to proceed to New York next month and

ANNOUNCING THE THIRTEENTH ANNUAL CONFERENCE OF THE OKLAHOMA CITY CLINICAL SOCIETY

OCTOBER 18, 19, 20, 21, 1943

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Dr. A. H. Aaron, MEDICINE, University of Buffalo School of Medicine.

Dr. Vilray Papin Blair, PLASTIC SURGERY, Washington University School of Medicine.

Dr. Louis A. Buie, PROCTOLOGY, Mayo Foundation, University of Minnesota School of Medicine.

Dr. Leroy A. Calkins, OBSTETRICS, University of Kansas School of Medicine.

Dr. Grayson L. Carroll, UROLOGY, St. Louis University School of Medicine.

Dr. Theodore J. Dimitry, OPHTHALMOLOGY, Louisiana State University.

Franklin G. Ebaugh, Colonel, M. C., NEUROPSYCHIATRY, Headquarters, Eighth Service Command, Dallas, Texas.

Dr. George B. Eusterman, MEDICINE, Mayo Foundation, University of Minnesota School of Medicine.

Dr. Clinton W. Lane, DERMATOLOGY, Washington University School of Medicine.

Dr. Harry E. Mock, SURGERY, Northwestern University School of Medicine.

Dr. Thomas G. Orr, SURGERY, University of Kansas School of Medicine.

Dr. Louis E. Phaneuf, GYNECOLOGY, Tufts College Medical School.

Dr. Robert D. Schrock, ORTHOPEDIC SURGERY, University of Nebraska School of Medicine.

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Dr. W. Likely Simpson, OTOLARYNGOLOGY, University of Tennessee School of Medicine.

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Dr. J. W. Ames, Vice-President, American Medical Association, Denver, Colorado.

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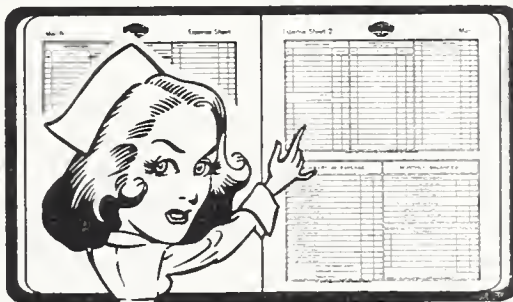
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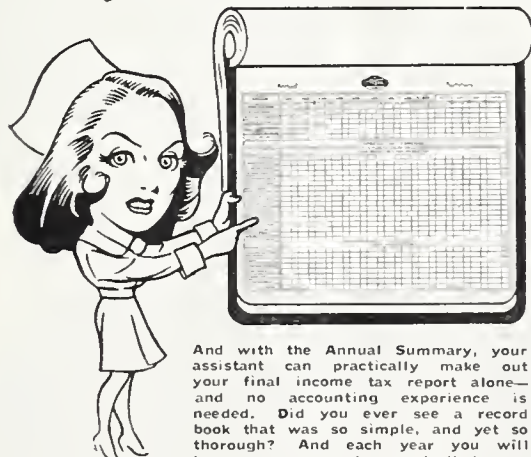
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from there with a motorized unit somewhere some time.

I suspect, since my movements will be rather sudden and often for the next few months, you might hold up The Journal temporarily. I enjoy reading it each month and just as soon as I land some place I'll drop you a card.

Henry Hollenberg and Jerry Levy are here. Both are doing fine work. Thanks for The Journal in the past.

Faternally,
H. K. Carrington

COMMUNIQUE

To the Editor:

Glad to get the "Random Thots." Keep having them and writing them down for us. Just hearing some of the fellows' names, or I should say, reading them, helps a lot.

About the Wagner bill. I can't write my senator. I've forgotten his or her name, and I usually keep up with such things too. However, I can find out and will.

Weddington's crew hair cut should not cause him to be called a sophisticate. There is only one thing more common among men in the tropics (I assume that is where he is located) and that is

known on this ship as "that crotch condition." The term covers any itching eruption confined to the inguinal and perineal portion of the body. The causative agent is of no consequence, and rightfully, because it soon simmers down to the same symptom in practically all cases, namely, an uncontrollable desire to scratch. I once heard my skipper say to our senior watch officer: hand me my binoculars if you can spare a hand." He was in the both hands stage. I eventually conquered his condition but not until he had spoiled several salutes to superior officers by frantically scratching at the wrong time.

Yours very truly,
Lt. Max Baldrige

COMMUNIQUE

To the Editor:

The Journal has been coming every month and I am very grateful for it. The communiques from the various men are very interesting. Couldn't we have more of them?

I am sending you a clipping from the West Virginia Medical Journal which gives evidence that I am on the job. As you will see from the photograph, I am not anticipating any happiness in the next few hours. Being the guest of the

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Crash Board on this investigation relieved me of any future curiosity.

All the "docs" back home must be extremely busy and possibly over-working, but even with that, September 15th gave me the first inclination to be happy that I am on the pay roll of the best Navy in the world.

Why not give us in the service more news items from the various county societies. Some of the experiences of the men bearing the weight of civilian practice in war time would be very interesting. A "Spider Rowland Column" would fit in well with "Random Thoughts." Why not give Joe Shuffield a chance for a rebuttal?

I hope The Journal keeps coming and through that medium I send my regards to all my friends.

Yours,

Raymond C. Cook
Lt. Comdr., M. C., U. S. N. R.
U. S. Naval Air Station Dispensary
Pensacola, Florida

COMMUNIQUE

To the Editor:

In 1942 I was not only available but on active duty. I thought it might be best for me to advise you concerning this matter, otherwise the news might not leak through to you prior to cessation of hostilities. Incidentally, do you still publish The Journal of the Arkansas Medical Society? Would suggest that you prove same to me because I want to be sure that you are still on the job and not merely sporting a bunch of titles.

Best wishes,

Gaston A. Hebert
Lt. Comdr., M. C., U. S. N. R.
U. S. Naval Hospital
San Diego, California

COMMUNIQUE

To the Editor:

In reply to your special bulletin, I am giving you my present address:

Lt. R. E. McLochlin, M. C. V. (S), USNR.
Bureau of Medicine and Surgery, Bldg. 2
23 and "E" Streets, N. W.,
Washington, D. C.

I will attempt to keep you informed of any change of address in the future, as I generally look forward to the receipt of The Journal with a great deal of pleasure.

Sincerely,

R. E. McLochlin



MEDICAL MEETINGS ARE ESSENTIAL, as essential in wartime as in peace, even more so. Physicians, military and civilian, need medical meetings, for it has been well said that "it is important that medicine not be frozen for the duration," and that "we must preserve and disseminate advances in medicine as never before." An essential meeting is the Southern Medical Association, Cincinnati, Ohio, Tuesday, Wednesday, Thursday, November 16-17-18. The Cincinnati meeting has been streamlined to meet wartime conditions, essential medicine brought down to date—a great wartime meeting. The Southern Medical Association is meeting in Cincinnati upon the invitation of the Campbell-Kenton County Medical Society of Kentucky. Newport and Covington are the principal cities of this two-county society and are across the river from Cincinnati. It is a Kentucky meeting.

REGARDLESS of what any physician may be interested in, of how general or how limited his interest, and whether in military or civilian practice, there will be at Cincinnati a program to challenge that interest and make it worth-while for him to attend.

ALL MEMBERS of State and County medical societies in the South are cordially invited to attend. And all members of state and county medical societies in the South should be and can be members of the Southern Medical Association. The annual dues of \$4.00 include the Southern Medical Journal, a journal valuable to physicians of the South, one that each should have on his reading table.

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The JOURNAL

OF THE ARKANSAS MEDICAL SOCIETY

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LITTLE ROCK, ARKANSAS, NOVEMBER, 1943

No. 6

THE DOCTOR'S HEART * †

J. H. MUSSER, M. D.

Coronary arterial disease has been referred to many times as the doctor's disease. The pathologic changes produced in the heart by sclerosis of the coronary vessels are responsible for the doctor's heart. That this term is not a misnomer can be substantiated by the vital statistics reports of the last few years. In 1942, for example, there were 3,329 deaths of doctors listed in the Journal of the American Medical Association. The causes of these deaths have been broken down in an editorial which appeared in the J.A.M.A. January 16, 1942. Heart disease was responsible by far for the greatest number of deaths amongst doctors. Of those physicians who died, death in 627 instances was reported as coronary thrombosis and occlusion with other coronary diseases, and angina pectoris listed to the number of 143. Eight hundred and thirty-eight deaths were the result of "disease of the heart and myocardium." There were listed also a considerable number of deaths as result of arteriosclerosis and its end results. Presumably a goodly number of these patients had coronary arterial disease as some of the diagnoses are quite inexact, indefinite and inconclusive, being reported merely as cardiovascular renal disease to the number of 217. Categorically there were listed then 770 deaths as result of coronary disease and presumably of the 838 physicians who died as result of other diseases of the heart and myocardium, sclerotic coronaries were responsible for the myocardial pathology in a large percentage of instances. After all, when the diagnosis is made of myocarditis, presumably it may be pathologically correct but the pathogenesis of the myocarditis in most instances is insufficient blood supply to the myocardium which in turn is dependent upon pathologic changes in the coronary vascular system. Certainly most of these deaths will not be

attributed to the other two great causes of heart disease, namely syphilitic and rheumatic heart disease. It is the exceptional doctor who dies as result of syphilitic heart disease; he knows too much about lues and is too keenly aware of the end results of syphilis to forego proper treatment. Only the occasional physician dies of rheumatic heart disease because by the time a man has become a doctor he has passed the usual period of life in which rheumatism may develop. Most persons with rheumatic heart disease develop it in youth and are not able to stand the physical rigors of obtaining a medical education.

As to other etiologic types of heart disease, certainly very few doctors die from a thyroid heart. Here again the physician is able to recognize his symptoms, obtain treatment before the thyrotoxicosis has caused heart damage to a considerable degree. This is a reversible type of heart disease and with the relief of the thyrotoxicosis the heart returns to normal. Other etiologic causes of heart disease are likewise extremely rare in the physician group.

The statements above are presented to substantiate the idea that coronary arterial disease is responsible for a large number of deaths in doctors and that many of the diagnoses that are not put down as coronary affections are also due to coronary disease. In other words, about one-third of the deaths of physicians in this country are due to the late effects of sclerosis of the coronary system. These deaths exceed by an enormous percentage deaths from any other cause. Cancer, which in vital statistics, ranks second as cause of death in this country, brought about the demise of only 181 doctors in 1942. Respiratory diseases caused the death of 239 physicians, 22 of whom died of lobar pneumonia. Under the very vague term of diseases of the gastrointestinal tract there were 139 deaths and 123 doctors died as result of accidents. It can be seen then that there were only a few causes of death which exceed 100 in number, whereas coronary disease was responsible for over 1,000 deaths of members of our profession.

* Read before the Sixty-Eighth Annual Session, Arkansas Medical Society, Little Rock, April 20, 1943.

† From the Department of Medicine, Tulane School of Medicine, New Orleans, La.

History

When one considers the figures that have just been given in regard to frequency of coronary disease among physicians, it is truly remarkable that this disease had never been recognized as a clinical entity until a short time ago. As a matter of fact it was not until World War I that the medical profession began to appreciate the importance of Herrick's observations first made in 1912, in a paper which raised practically no comment, discussion or outstanding interest. As a matter of fact Herrick speaks of this paper as being dud. The second paper was a big bomb which went off with tremendously devastating effects. In a short time physicians became coronary artery conscious and a series of excellent papers by such men as Libman, White, Levine, Pardee, Wolferth and others substantiated Herrick's thesis and added additional clinical observations as well as pathologic and electrocardiographic information about the disease which has resulted in a clear-cut, readily diagnosed syndrome about which there is little that is not known.

Etiology

The primary etiology, of course, is arteriosclerosis. Sudden obstruction of a normal coronary vessel may occur as result of embolism but it is extremely rare. More frequent indeed is the gradual obstruction which is the result of arteriosclerosis and which suddenly, in most instances, closes up as a result of intravascular thrombosis. It is one of the most common causes of sudden death.

Why occlusion takes place in the coronary vessels frequently, and rarely elsewhere, and why the coronary vessels of the body are the site of highly developed sclerotic changes when the other vessels of the body show but little change, are moot points. It is probably the coronary vessel which biologically is one of the oldest arteries in the body may be the subject of certain developmental faults which throw a greater strain upon it than does the ordinary blood vessel suffer elsewhere.

The diabetic is prone to have arteriosclerosis and is also prone to have coronary occlusion which is one of the most important etiologic conditions predisposing to the disease. Hypertension is another antecedent disorder which is usually always stressed but I will remind you coronary occlusion occurs frequently in people who do not have elevation of blood pressure. I could recount instance after instance of people who have had regular physical examination, at which time the blood pressure was normal, and

who have died a sudden cardiac death.

Heredity is of extreme importance as an etiologic factor. Just as there are families who are hypertensive families and whose members die at a young age, just so are there families in whom coronary disease is remarkably prevalent. I know of one doctor's family tree in which 10 or 11 of the doctors died a sudden heart death which undoubtedly was the result of coronary disease.

Men are more frequently attacked than women. There are all kinds of figures to bear out this statement, some of which give only a slightly higher percentage in the male than female, others in which there is a marked predilection for the male sex. Personally I rarely see a woman with coronary occlusion, but frequently men.

Pathology

The occlusion may take place without the production of an area of infarction. This occurs in the gradual and slow occluding processes which are not particularly dramatic in their expressions. On the other hand, in the patients who have clear-cut symptoms which are highly characteristic there is usually infarction present. But this infarction is never as great as one would anticipate from the size of the vessel that is occluded and which supplies a goodly part of the blood to that area of the heart. This is dependent upon the fact that there is extensive anastomosis between the right and left coronary vessel and these anastomoses in the left ventricle at least produce collateral circulation which is more pronouncedly widespread in the older individual than in the younger.

Blood will be supplied to the infarcted area and healing may take place because a new source of blood supply will be evolved and the existing mechanisms for delivering blood to the heart will be augmented. The Thebesian vessels will supply a greater amount of blood to the heart. Anastomoses I have just mentioned. Extracardiac anastomoses may be present and blood may be forced into the coronary vessel itself up to the area of occlusion by the to and fro pumping action of the heart.

Symptomatology

The story of coronary occlusion is in most instances typical. The severe substernal pain that occurs frequently without any initiating factors, as the occlusion which occurs at night time when the patient is in bed. The pain is persistent, does not disappear promptly with nitroglycerine but lasts from six to 36 hours, and gradually subsides after the initial severity. On

the other hand, there are dubious cases in which the pain may be more or less transitory or even non-existent. The pain, instead of being referred down the left arm, may be referred to the right shoulder and arm. The epigastrium may be the site of the pain so that when associated with vomiting a series of symptoms is produced which are often mislabeled acute indigestion, acute gastritis or acute cholecystitis. In patients who have no pain there does occur severe shortness of breath which is apparently causeless. Irrespective of whether or not pain is present a patient usually shows the customary expressions of shock. Of course in those patients who have associated severe pain, these shock symptoms are often predominant and outstanding. To be cautioned against is what I may speak of as deceiving drop in blood pressure. The patient has the symptoms of shock and the blood pressure is found to be 138/85, figures which are not at shock levels. It is advisable for the doctor, if he does not know the patient to inquire of him what were the previous blood pressure readings. In most instances he will find these are hypertensive people who have had drop in blood pressure of 50 to 70 mm. mercury.

Dyspnea is a symptom which must not be neglected. The sudden occurrence of shortness of breath without pulmonary edema and without any attributable cause may be the chief manifestation of coronary occlusion. The symptoms of heart failure may occur promptly but congestive failure is not of immediate moment but more likely to occur days after the initial insult.

Physical Signs

The immediate physical signs are those of a heart that is working under stress. Gallop rhythm may be heard, the apical impulse may be indefinable and the heart sounds may be weak. In about 40 per cent of instances irregularities will occur, usually ectopics but once in a while the heart rate falls to a very low figure as result of the area of infarction extending to the bundle of His and producing heart block. The very rapid heart rate, ventricular tachycardia, is a cause for worry. Ventricular tachycardia may precede the ventricular fibrillation which causes the patient to die. Forty-eight to 72 hours after the initial blow, the signs of relative insufficiency, such as systolic mitral murmur, may be heard. This likewise is the time that the friction rub may be noted. It is often very evanescent; it may come and go; it may come, last for only a short time, a few hours, and never reappear. If there is posterior

wall infarction it will not be heard as only noted when there is considerable area of infarction as result of occlusive thrombosis of the anterior descending branch of the coronary artery. Fever is noted and the usual physical signs that are associated with fever will be observed.

Laboratory Examinations

Leukocytosis is present and is in direct relationship to the size of the infarct. The same statement applies to the elevation of temperature that occurs six to 48 hours after the onset. The electrocardiogram is of great diagnostic value. Serial changes take place in the electrocardiogram which are of great moment. Early in the course of the disease the most characteristic finding is high take-off of the T wave and widening of the QRS interval. The T wave undergoes progressive changes and ultimately becomes isoelectric and finally negative.

The After Events

The patient may die very promptly as result of shock, ventricular fibrillation or even, but rarely, heart failure. Death occurring a few days after the initial attack is likely to be the result of heart failure, emboli, heart block or even rupture. Patients may improve for a time and then begin to develop the signs of heart failure which may cause their death, within a few months. About 30 per cent of patients will die in the first attack. I do not think that the figures that have to do with survival of the patient are accurate. Many a patient has a small area of infarction which is undiagnosed and probably the figures of the first attack causing death and the survival figures would be considerably modified if we were sure that the first and second attacks were always recognized. It is my belief that coronary occlusion and infarction are not as lethal as generally considered.

A certain group of patients who survive will eventually develop heart failure.

Treatment

Immediate treatment, of course, is complete physical and mental rest. The patient should be given a large dose of morphine sufficient to control the pain. Papaverine is coming into favor because it does not have the vasoconstricting effect that morphine does, working through the vagus. Unfortunately papaverine is not in my experience sufficiently powerful to relieve pain in many instances, so morphine must be used but as soon as possible switch to papaverine and replace the more powerful morphine. Shock is treated by the usual methods, principally rest plus the slow introduction of five per cent glucose

into the vein. When stimulants are needed caffeine sodium benzoate in doses of one-half gram hypodermatically is probably the best stimulant.

The after care of the patient is of importance. The usual procedure is to keep the patient absolutely quiet for three weeks and then let him start to do very light exercise such as going to the toilet but if the fever has been high and the area of infarction seems to be quite extensive, more physical work than movement to the bathroom should be restricted for an additional three weeks. Fairly complete physical rest is indicated for at least six months. This is a controversial point because there are some cardiologists who maintain that the circulation to the heart is vastly improved by physical work, modified of course and considerably restricted. This is a rational point of view but I must confess that I would be timid rather than bold and would prefer to follow the long rest regimen which has been used widely and generally.

In patients who have had a recognized attack of coronary disease I believe it is advisable to give aminophyllin more or less continuously for months or even years. This is on the basis that these xanthine preparations are capable of increasing coronary circulation. Aminophyllin is sometimes disturbing to the stomach, therefore theocalcin may be used as a substitute although it is probably sometimes less effective than aminophyllin in increasing coronary blood flow. In patients who are nervous and high strung theominal may be given or if it is considered preferable to give a phenobarbital by itself this may be done.

Summary

Only the highlights of coronary occlusion have been discussed. Two particular points should be stressed: (1) early diagnosis, and (2) proper after care.

COMMUNIQUE

To the Editor:

Am writing to furnish you with the above address. Have been getting The Journal regularly, if a little late. Enjoy every number and have enjoyed reading in The Journal the reproduced letters from such noble members as Bowman, Buckelew, Ellis and others. Have been unable to locate Jack Ellis and am beginning to doubt if he's anywhere in Willkie's One World.

Frank M. Burton, Major, M. C.,
128th Evacuation Hospital (Overseas).

THE MEAD JOHNSON VITAMIN B COMPLEX AWARD

Nominations are solicited for the 1944 award of \$1,000 established by Mead Johnson and Company to promote researches dealing with the B complex vitamins. The recipient of this award will be chosen by a committee of judges of the American Institute of Nutrition. The award will be given to the laboratory (non-clinical) or clinical research worker in the United States or Canada who, in the opinion of the judges, has published during the previous calendar year January 1 to December 31 the most meritorious scientific report dealing with the field of the B complex vitamins. While the award will be given primarily for publication of specific papers, the judges are given considerable latitude in the exercise of their function. If in their judgment circumstances and justice so dictate, it may be recommended that the prize be divided between two or more persons. It may also be recommended that the award be made to a worker for valuable contributions over an extended period but not necessarily representative of a given year. Membership in the American Institute of Nutrition is not a requisite of eligibility for the award.

To be considered by the committee of judges, nominations for this award for work published in 1943 must be received by the secretary, Arthur H. Smith, Ph.D., Wayne University College of Medicine, Detroit, by January 10, 1944. The nominations should be accompanied by such data relative to the nominee and his research as will facilitate the task of the committee of judges in its consideration of the nomination.

COMMUNIQUE

To the Editor:

Back from New Guinea and Australia with a slight case of chronic arthritis, hospitalized here at Temple. Sent back to the States to prove or disprove hyperarathyroidism as I suffered a generalized demineralization while in New Guinea with first station hospital that landed on the island.

Haven't seen a Journal in over a year. Please advise if I'm on the delinquent list for dues.

Sincerely,
Winston C. Riggins, Lt., M. C.,
McCloskey General Hospital,
Temple, Texas.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

MUCH USED by both internist and surgeon in other fields of medicine, the fluoroscope has proved a valuable aid in the diagnosis of pulmonary lesions and in the periodic recheck of their progress. A competent examiner, using good equipment, is often able to secure information that may not be ascertainable by means of conventional films, such as the movements of the diaphragm, the contrasting appearance of the expanded or contracted lung, the effect of moving the thorax into different positions before the screen. Warnings that this method should supplement, not replace, good chest films have been frequent. Here is a timely warning of another danger—one inherent in the physical properties of the electric current and of the roentgen ray. This Safety First appeal merits serious thought.

DANGER FROM FLUOROSCOPY

A number of articles have been published concerning the dangers connected with fluoroscopy. Recent measurements have shown that these warnings must be taken seriously and that they concern the whole medical profession. The problem is more acute now when the serious film shortage may call for more extensive use of the fluoroscopic method, and it seems advisable to call attention to a few pertinent facts.

No fluoroscopic unit should be used unless the doctor in charge has convinced himself that the conditions under which it is operated are reasonably safe. A continuous vigilance is necessary, and it is not enough to know that the conditions were satisfactory at one time in the past.

A shock-proofed arrangement should remove electrical dangers but a broken cable or a casual repair may lead to electrical hazards, and many of the old machines have exposed high-voltage leads. Grounding a part of the apparatus may not always serve as protection, and if the ground is applied at the wrong place the danger may be increased. A careful expert inspection is needed and there can be no valid excuse for an accidental electrocution. Such accidents have occurred a number of times.

Roentgen rays from fluoroscopic units have caused innumerable sequelae to both patients and physicians, and serious damages often still result in spite of the knowledge that now is available.

In order to obtain adequate protection, it is first required that the tube be shielded so that no radiation of any consequence escapes in any direction except in the useful beam. This may be checked roughly with a hand fluoroscope or more accurately with a roentgen meter with a sensitivity of 0.01 r or a Geiger-Muller Counter. After this first requirement has been fulfilled several other precautions must be taken.

For any intelligent use of fluoroscopy, it is important to know the amount of roentgen rays reaching the skin of the patient and of the examiner, and that has to be determined by means of measurements. The total dose received depends upon the intensity and the time of exposure. The intensity depends upon a number of factors and varies widely in practice. A reasonable intensity at the skin of the patient nearest to the tube amounts to about 20 r per minute.

A representative of the division of Biophysics, University Hospitals, has recently checked some machines in Minnesota, and has found intensities during routine practice up to 114 r per minute. It is evident that such an intensity is dangerous and must be reduced by proper adjustments. The question is how many of the machines which have never been calibrated are used under similar conditions with an unnecessarily high intensity.

The intensity may be reduced by increasing the distance from the target to the patient.

This distance should be at least 28 to 30 cm. It can also be reduced by lowering the current which should not exceed 4 to 5 ma. If the fluorescence is not bright enough the voltage may be raised and it is advisable to use rather high voltage, preferably 80 kv. or 100 kv. if possible with the equipment. With a high voltage a filter helps to lower the intensity considerably and a 1 mm. aluminum filter should be permanently attached.

With the use of 28 cm. target skin distance, 90 kilovolts and 4 ma. and 1 mm. aluminum filter, the intensity can undoubtedly be kept within the safe range, but it is still advisable to have it measured so that the number of roentgens applied per minute will be known.

The time used for an examination should be kept at a minimum. It should be measured and recorded. A foot switch should be used so that the current applied to the tube may be limited to the time of inspection. The use of a timer, which sums up the exposure and shuts off the machine when the dose decided on has been given, is advisable.

Some fluoroscopic examinations require an exposure of 5 minutes. With an intensity of 20 r at the patient's skin, this means a dose of 100 roentgens. A dose of 75 r is often used for treatments of skin diseases and the title of a publication in *The Journal of Radiology*, "Roentgen Therapy in Fluoroscopy" is, therefore, no exaggeration.

The rules laid down here for the safety of the patient may seem drastic. They are, however, not difficult to follow after they once have been accepted and certainly patients have the right to expect the physician to take the necessary precautions in order to avoid serious injury from a simple examination. These rules also help to protect the examiner, though any injury to him is due to accumulation of exposure over a long time rather than to a single dose. He must be particularly careful to protect the hands which are inevitably exposed at palpation during the fluoroscopic examination. The use of lead-rubber gloves may help but not unless the gloves are heavy and designed to shield the whole hand can they be relied upon to give complete protection. Light gloves may give a false sense of security. The examiner must in any case be aware of the danger and take all precautions possible.

The most dangerous procedure and the one which has caused most of the injuries is the setting of fracture under fluoroscopic visualization. This practice must be condemned and the

radiologist in charge should enforce the rule that nobody on the staff be permitted to use the apparatus in this manner. The doctor may receive enough exposure from the setting of a single fracture to produce a severe skin reaction. It is, of course, good practice to inspect the position fluoroscopically and that can be done several times without exceeding the permissible total dose.

A number of physicians already have suffered the consequences of too much exposure during fluoroscopy. They have been severely handicapped and some have paid with their lives. The tragedy has been extremely impressive, and it is hoped that others will heed the warnings before it is too late.

Danger from Fluoroscopy, K. Wilhelm Stenstrom, Ph.D., Professor of Biophysics, University of Minnesota, Editorial, *Minnesota Medicine*, June, 1943.

COMMUNIQUE

To the Editor:

Just a line to let you know how much I enjoyed the "Random Thoughts" letter. We'd like to see them often.

We've been pretty busy out here and I can tell you that the old Arkansas boys have really been on the ball.

The scenery is wonderful here, but awfully monotonous, and I'd quickly swap it all for one look at Arkansas. For one thing, it's usually windy. The wind may blow fifty or sixty miles an hour for several days, then it cuts loose and blows hard for a while.

The "Kee" birds that are plentiful in this region are interesting. Due to poor flying conditions such as fog, wind, rain and so on, they are never able to fly and consequently their wings have atrophied. Now all they do is walk about on the hills crying, "Kee-rist it's cold!"

Yours,

Lewis Hyatt.

COMMUNIQUE

To the Editor:

Greetings from the Vapor City.

Have you heard about the moron who put his wife in union-alls to help her with her labor troubles?

Our best to all of you there and any of the boys that you may see.

Sincerely,

Byron A. Bennett, Major, M.C.,
Army and Navy General Hospital,
Hot Springs National Park, Arkansas.

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EDITORIALS

A MEDICAL OFFICER'S VIEWS ON
POSTWAR MEDICINE*

MAJOR WM. B. HARRELL, M. C.
Little Rock

Recently, I have received letters from some of
my colleagues remaining in civilian practice, in
regards my impression of the transition that we
medical officers serving with the armed forces
will have to sooner or later go through when we
return to civilian life. Perhaps some of these
letters to me were prompted by the recent
gratifying news reports coming from the fight-
ing fronts or perhaps by the pending legislation
which if passed would create a completely
socialized system of medicine for the people of
the United States. At any rate I think that many
of the doctors remaining in Arkansas will be in-
terested in what we civilian soldier medical of-
ficers are thinking and for that reason I have

consented to express my ideas as an individual
which in all probability will be more or less similar
to those of many other medical officers.

When many of us were ordered to active duty
in 1941 we naturally felt that we would return
to civilian life at the expiration of the year's
training period. Consequently, we made plans
accordingly. For some few weeks before Pearl
Harbor, however, we had a feeling that the end
of the first year's training period would only
mean the beginning of a second year in the Army
and we gradually put aside the thoughts of re-
turning to civilian life, and began to think of the
many places that we might be needed as medical
officers should the nation go to war.

Naturally, after December 7th, 1941, most all
of us volunteered for foreign duty and many
of us were shipped out within a short period of
time. It has not been my good or bad fortune
as yet to take part in any of the battles per se
and I have been stationed most of the time in a
Station or Numbered General Hospital. Al-
though we have had many inconveniences,
especially during the past two years, I am of the
opinion that the doctors who have served con-
tinuously with the tactical units are the men who
have had the most hardships to endure. Many
of these officers had only completed one year
internships when they entered the service and
it is going to be much more difficult for them to
adjust after the war, than it will be for some of
us who had been out of school longer before
entering the service. On the other hand many
of these younger officers may see fit to make
the Army a career, providing it is possible to
remain in the service.

In the event that these officers who were
called into the service the second year out of
school elect to return to civilian practice and
desire further medical training it seems only
logical that they should receive priority on all
hospital appointments such as residencies and
university fellowships. Of course there will be
certain officers in this category who will have
received ample training by working under super-
vision in a hospital unit while in the service. It
appears to me that these officers who would be
ready to enter civilian practice after taking a
short postgraduate course in one of the uni-
versities.

Most of us have had shorter working hours in
the Army than we had in civilian life, and conse-
quently more time to think about plans for our
personal medical career as well as the future of
American medicine. Along with this comes an-

* Received as a communication by the editor and reprinted for
the serious consideration of all members.

other factor which has some influence on most medical officers, namely, the melting pot associations. It has been my pleasure while serving in the Army to work with doctors from most every state as well as many foreign graduates. Naturally we have exchanged ideas on many subjects and have discussed at length the medical setups in our respective states or countries as the case may have been. Many of these doctors have expressed themselves at times in certain ways that would lead me to believe that they were not satisfied with the setup in their former home state or country. Being a member of the Arkansas Medical Society and Southern Medical Association I have been approached by many of these doctors who were desirous of obtaining a license to practice medicine in one of the southern states at the conclusion of the present war.

Most of the medical officers feel that it will not be difficult to get a license in any state during the postwar era providing the doctor has served in the medical corps during this national emergency. It must also be remembered that many of these medical officers have graduated from schools that are not recognized by the American Medical Association and in many cases from foreign medical schools.

A great many of the medical officers that I have talked with believe that there will be a need for medical officers in some of the occupied countries following the war and that the foreign graduates and refugee doctors might well fit into this setup. It is true that the government is educating hundreds of doctors in a relatively short time now and one can readily see where it might be necessary for some of these men to serve in this capacity also.

Recently, I was talking to a medical officer who had more or less reached his peak in private practice before entering the service and because of the fact that he was in the middle age group felt that it would be better for him after the war to get a position in a Veterans Hospital rather than attempt to establish another practice. Personally, it appears to me that many of the older doctors who are serving in the Army now might well take advantage of such position vacancies and receive priority on the same.

A constant source of worry now for those of us who have been out of school approximately eight years are the rigid requirements of the various Speciality Boards that we had hoped to qualify for at this time in our medical career. It is true that the Boards have agreed to accept some of the work done in military hospitals in

lieu of civilian training, however, most of us feel that we could very advantageously take another year's training in a civilian medical institution before attempting to pass the Board. For this reason very few of the officers that I know who had completed residencies before entering the service are planning on taking the Board examinations at this time.

The doctors in the service favoring socialized medicine that I have known personally have been men who because of one reason or another are afraid of competitive medical practice. It may be a case of inadequate medical training or in some cases proficient training in medical administration which they think will be a tremendous asset to them in a socialized scheme of medicine. Most of we younger men however do not favor complete socialization and prefer to return to our former home states and attempt to establish a practice with the few extra dollars that we may have saved.

MATERNAL AND CHILD WELFARE PROGRAM DISCONTINUED BY STATE BOARD OF HEALTH

At its meeting October 14th, the Arkansas State Board of Health voted to discontinue participation in the Federal program for obstetric and pediatric care of the wives and infants of enlisted men. The effective date for discontinuance will be when the October allotment of funds has been allocated by the State Board of Health, which is not expected to be later than November 1st. After that time, no further applications will be accepted although all obligations which have been incurred and approved will be paid as they come due through rendition of services.

The medical profession has been placed in a most unfortunate dilemma by imposition of this Federal plan. On the one hand, physicians cannot accept the plan as offered without submission to the dictates of a governmental agency, while, on the other hand, they will find it difficult to seem to deny the families of service men benefits which are offered them, benefits which, it is felt, would have been theirs, governmental plan or not.

The principal objections of the medical profession to the plan is that it compels physicians to serve a considerable number of their patients seeking maternal and pediatric care at a fee established by governmental agency; that it does not consider the need for financial assistance; that it denies both the physicians and the patient the right to mutually arrange for supplementation

of this fee; that the fee is all-inclusive with no provision for complications which may ensue, and that the fees set are below the reasonable value of the services.

The medical profession does not need to call attention to the fact that it has been glad to serve the public for compensation within the limits of the public's ability to pay. Many of our citizens are served without fee of any kind. The dependents of enlisted men will continue to receive medical care in the traditional manner. The physicians of Arkansas do not intend to permit the family of any enlisted man to suffer from the lack of medical care, whether such be obstetric, pediatric, surgical or medical.

W. B. GRAYSON—A TRIBUTE

On November 15th, Dr. W. B. Grayson relinquishes his post as state health officer, an office he has held with distinction and credit for the past ten years. Throughout these years of service he has constantly sought advancement of public health in Arkansas, serving the people of Arkansas efficiently and earnestly, always in a proper public health way. His relations with the physicians of Arkansas have been most harmonious and he has never failed to seek the advice of the medical profession in the activities of the health department. This cooperation is appreciated by the physicians of Arkansas who have, in turn, given the health department their full support. The growth of the Arkansas State Department of Health under the direction of Dr. Grayson has been phenomenal and has brought him national recognition as a public health administrator. The best wishes of his many professional friends go with him as he now returns to the private practice of medicine.

COMMUNIQUE

To the Editor:

My address has changed and I'm writing you as I hope to get The Journal and keep in touch as much as possible with what the boys are doing, and to answer your mimeograph letter.

Here in * * * we see many strange and oriental sights, disease, poverty, and dirt alongside a favored few who enjoy freedom, luxury and power. There are many millions here who are underfed and because the people themselves are divided they cannot throw off the * * * rule which keeps them in poverty.

Our work is among the soldiers and the camp followers who come over from home as the

"special assistants," "technical advisers," "ambassadors extraordinary" and other draft dodgers.

Thanks for The Journal. Sorry about the finger. Do you have any witnesses to prove how it happened?

Sincerely,

Fount Richardson, Major, M. C.

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1943-1944

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* In military service.

PROCEEDINGS OF SOCIETIES

The Fifth Councilor District Medical Society met in dinner session at Camden October 7th for the following program: "Carcinoma of the Prostate," H. King Wade, Hot Springs National Park; "Fractures of the Hip," Jos. F. Shuffield, Little Rock; "Medical Education," Byron L. Robinson, Little Rock, and "The Wagner-Murray Bill," W. R. Brooksher.

The Pulaski County Medical Society was addressed October 4th by Mr. A. L. Barber on the Wagner-Murray Bill.

Elizabeth D. Fletcher, Secretary.

The Craighead-Poinsett County Medical Society met in dinner session at Jonesboro October 7th for the following program: "Highlights on the Federal Maternal and Child Welfare Program and on the Wagner Bill," P. W. Lutterloh; "Remarks on the Wagner Bill," Messrs. A. P. Patton and Arthur Adams; and "The Wagner Bill from the Insurance Angle," Mr. D. B. Acoc.

J. H. McCurry, Secretary.

The Sebastian County Medical Society was addressed October 12th by Maj. Edward Castle, "Intestinal Obstruction," and Maj. David Schwarz, "Backache," both speakers from Station Hospital, Camp Chaffee. A Dutch lunch was served by the Woman's Auxiliary following the scientific session.

W. F. Adams, Secretary.

A streamlined process of Penicillin production, resulting from two years' research in the Parke-Davis Laboratories, promises to substantially cut down the production time required, according to Homer C. Fritsch, General Manager of the Company.

"The present method of producing penicillin requires from 6½ to 14 days," he said in an interview recently. "We have advanced our methods to where we can produce in 2½ to 3 days without using cumbersome equipment."

This constitutes a significant forward step, since the bottle-neck in the Penicillin situation, to date, has been the fact that the drug has been available only in comparatively small amounts. Parke, Davis & Company is now regularly supplying Penicillin to the government and has recently expanded its facilities for producing the new "miracle" drug.

PERSONALS AND NEWS ITEMS

Capt. Hugh J. Mayfield, El Dorado, is now in service overseas.

Lt. Ben H. Pride, Fort Smith, is now stationed with the Air Force at Tarzana, California.

Dr. and Mrs. M. E. Foster, Fort Smith, spent a recent vacation in Colorado.

J. L. Kellum, Fort Smith, spent a recent vacation in Mississippi.

Capt. Jack R. Ellis, Hot Springs National Park, is serving with a troop carrier squadron overseas.

MARRIED—On October 7th, W. O. Arnold and Miss Sarah Weaver, State Sanatorium.

"Cardiac Aneurysm: Report of a Case with Correlation of Clinical, Radiological and Electrocardiographic Findings" by E. Driver Rowland, Hot Springs National Park, now in military service, appeared in *Annals of Internal Medicine*, August, 1943.

T. H. Jones has been discharged from military service and has returned to practice at Waldo.

H. W. Savery, Van Buren, spent an October vacation in Colorado.

E. C. Moulton, Fort Smith, attended the recent Chicago session of the American Academy of Ophthalmology.

John E. Greutter, Little Rock, has been promoted to captain.

Capt. Wm. O. Loftis, Pocahontas, is now on duty at the Red River Ordnance Depot, Texarkana, Texas.

Norman W. Peacock has moved from Mena to Ashdown.

MARRIED—On October 16th, Chas. Wallis and Miss Dollye Holt, Little Rock.

C. Ray Williams, Morrilton, now stationed at Hendricks Field, Florida, has been promoted to captain.

Capt. J. L. Aday, Little Rock, is now on duty overseas.

Vincent O. Lesh, Fayetteville, now stationed at Camp Adair, Oregon, has been promoted to major.

W. B. Grayson has submitted his resignation as state health officer to take effect November 15th.

Capt. Homer K. Wright, Hot Springs National Park, is now stationed at Station Hospital, Fort Bliss, Texas.

J. M. Walls, Blytheville, now stationed at Camp Gruber, Oklahoma, has been promoted to major.

Walter Myers Smith, Little Rock, now stationed at Washington, D. C., has been promoted to captain.

Capt. Ed Dunaway, Conway, is now on duty with the 137th Station Hospital, Fort Bliss, Texas.

Ulys Jackson, Blytheville and Harrison, is now on duty overseas.

BORN—October 19th, a son, to Dr. and Mrs. Martin Even, Fort Smith.

Clyde D. Rogers, Little Rock, now stationed at Ellington Field, Texas, has been promoted to major.

A. C. Shipp, Little Rock, and J. D. Riley, State Sanatorium, have been elected president and vice-president, respectively, of the Arkansas Tuberculosis Association.

Jeff Baggett has been transferred to inactive reserve, medical corps, and has resumed practice at Prairie Grove.

Guy Shrigley, Clarksville, now stationed at Fort Ord, California, has been promoted to captain.

G. R. Siegel has been elected post surgeon of the Clarksville post of the American Legion.

RANDOM THOUGHTS OF THE SECRETARY

September 26th. Again visiting Denver but not via Atlantic City, etc., as some of our confreres would insist is the custom. This night we meet the difficulties of food supply, the restaurants either being closed, filled to capacity, or out of food, our first experience with this horror of the civilian front.

September 30th. We have met and conquered another of life's difficulties. Aboard a Pullman the 27th while engaged in pursuing hygienic measures of dental care, our one-tooth removable bridge slipped from the hand and down the dental lavatory pipe. The shortage of dentists, of gold and of time, being what it is, we are most grateful to the Pullman Company for calling in the plumber and returning our lost tooth.

October 5th. Breakfasting with Major Sam Phillips, now at Winter General Hospital, Topeka, and bringing him up to date with Arkansas news and then with him to the sessions of the Kansas City Clinical Society where the 1943 attendance is the greatest ever. Tonight we listen to a panel discussion on the future of medical practice where labor's representative frankly presents reasons for their support of S. 1161.

October 7th. A great crowd attends tonight's meeting of the Fifth Councilor District Medical Society in Camden, all patient with necessary delays. When it is suggested that we talk to while away the time awaiting meal service we realize just what we must have been doing all these years and wonder if it is yet possible to reform.

Among those present are Grayson, now working for the love of humanity; Fincher, who claims that all children should come of the pattern as his new daughter; Jones, from Waldo and late of the army, with comments on medical service with the armed forces not calculated to support appeals for additional medical officers; Mrs. Joe Wharton, Jr., whose presence prompts us to again ask that the members write our colleagues away in service, and George Fletcher who finds that King Wade's promise of paying for a meal can be no more than a promise. Away in haste to make a bus out of Little Rock with Shuffield at the wheel and Byron Robinson for incidental conversation, seeing no foxes on the highway this trip, possibly because they could not keep the pace.

October 10th. Riding trains all day long for the pleasure of a brief noon session with the Arkansas State X-ray Society and tonight having as traveling companion Major Stanley M. Gates, who is well informed on all subjects but the army.

October 12th. Tonight the army furnishes the scientific pabulum but the good Auxiliary ladies provide point-food in abundance and the social side is enthusiastically presented.

October 13th. Jointly engaged in a diagnostic cancer clinic at Mena today with Ewell Thompson and, without undue boasting, we can claim to have seen our share of patients this one afternoon. From far and near they come, bring their varied ailments, giving Thompson an opportunity to see many keratoses but few actual malignancies.

October 16th. Climaxing a two month's effort, I. F. Jones today presents us with the first letter for one of our members overseas. We are still of the opinion that more letters should be written to our members in military service and will gladly forward all to correct military addresses if first sent to our office.

OBITUARY

EDWARD RUSH KING, age 51, Ashdown, died suddenly of a heart attack September 24th. Born in Sevier county, he graduated from the University of Tennessee College of Medicine in 1915 and had been continuously in practice at Ashdown since graduation. Surviving relatives are his wife and two sons.

GEORGE KELLOG STEPHENS, age 64, died at his home in Newport October 5th. Born at Jacksonport, July 30, 1879, he graduated from the University of Arkansas and then received his medical degree from Washington University School of Medicine in 1902. He had been in practice in Newport continuously since graduation. He was married to Miss Louise Irby in 1905. In addition to his membership in the Jackson County Medical Society and in the Arkansas Medical Society, he was a fellow of the American Medical Association. Surviving relatives are his wife, two sons and a daughter.

AMEBIASIS

The incidence of amebiasis has been shown to be greater than was formerly supposed, and there is reason to believe that the disease may become even more prevalent when large numbers of troops begin to return home from the tropics. Surveys collected before the war revealed that more than one in ten subjects harbored *E. histolytica*. It would seem reasonable, therefore, that whenever intestinal symptoms form a part of the clinical picture, the diagnosis should not be considered complete until the possibility of amebiasis has been ruled out. Chronic, uncomplicated intestinal amebiasis is the most frequent type, and it includes the carrier as well as the individual with recurrent or mildly persistent symptoms. Pulvules Carbarstone, illy, each containing 0.25 Gm., may be given orally at the rate of one pulvule two or three times daily to a total of twenty doses (5 Gm.). This routine may ordinarily be repeated several times, provided intervals of ten days are allowed between courses and the urine and liver show no evidence of damage. Bed rest is not necessary in this group.

WOMAN'S AUXILIARY NEWS

TEN WAYS TO HANDICAP AN AUXILIARY

1. Seldom, if ever, go to an Auxiliary meeting.
2. If you do attend, find fault with the work of the officers.
3. Never accept an office. It is easier to criticize than to do things!
4. If asked by the chairman to give your opinion regarding some matter, tell her you have nothing to say. But say PLENTY after the meeting!
5. Do nothing more than is absolutely necessary; but when other members roll up their sleeves and willingly and unselfishly use their ability to help matters along, howl that the Auxiliary is run by a clique.
6. Hold back your dues as long as possible, or don't pay at all.
7. When parties or other "affair" benefits are given, tell everybody money is being wasted on "blowouts" which make a big noise and accomplish nothing.
8. When no parties are held, say the Auxiliary is dead and needs a few good members like yourself.
9. Don't tell the Auxiliary how it can help you, but if it doesn't help you, resign.
10. Keep your eye open for something wrong and when you find it, resign.

BOOK REVIEWS

The Compleat Pediatrician: By W. C. Davison, M. D., Professor of Pediatrics, Duke University School of Medicine. 4th edition. Durham, North Carolina: Duke University Press, 1943.

This very complete text on pediatrics is in its fourth edition. The amount of material covered is amazing. Much larger texts do not contain as much information. This edition includes essential information on 1,500 recent pediatric articles in addition to the 11,554 of the previous editions. 7,000 lines have been changed and added items are on chemotherapy, tropical and infectious diseases. The value of this inexpensive text cannot be sufficiently stressed and the reviewer recommends its purchase by all who treat children, whether specialist or general practitioner.

Dr. Colwell's Daily Log for Physicians. Price \$6.00. Champaign, Illinois: Colwell Publishing Company, 1943.

This one-volume record system for physicians enjoys increasing popularity and, once used, tends to become a fixture in the physician's office. In addition to the tried features which are retained, a simple record sheet is included in the 1944 volume to provide for computations of estimated and actual Federal income tax. To those physicians who have not used this record system, we urge a one-year trial.

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COMMUNIQUE

To the Editor:

A few lines to say that I thoroughly enjoy your Army bulletins. They are swell and keep us posted on this fellow and that one whom you so often wonder about.

I am glad to note that the Arkansas doctors are really taking this Senate Bill 1161 seriously. That bill is a malignant thing and good old John Q. Public will really get a reaming if it passes. I wrote to Mrs. Caraway about it and will also write McClellan. I think all of us had certainly get on the ball to prevent the passage of it. Boy, what a gold mine of political easy money the Bureaucrats would get if the thing passed. The doctors in the Army are very concerned about the Wagner bill; they are putting in their protests to their various Senators and they all feel that the doctors back home want to really get in their two-bits worth, too.

Yours,

M. B. Bowman, Capt., M. C.,
Turner Field, Georgia.



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CARDIAC ARRHYTHMIAS *

O. C. MELSON, M. D.

Little Rock

Cardiac arrhythmias may be due to functional disturbances of the heart beat or they may reflect some serious disturbance of the cardiac conducting mechanism. In the first instance, they disturb the patient and arouse a sense of apprehension of some serious heart ailment. Secondly, they may either cause some disabling condition or they may lead to the discovery of some underlying disease which might otherwise be overlooked.

Although electrocardiography has clarified many of these arrhythmias, it is not necessary to obtain a tracing in all cases to make a diagnosis. However, one having a knowledge of electrocardiography may find it easier to diagnose these irregularities clinically. It is not enough to palpate the pulse but careful auscultation of the heart beat is necessary to differentiate the various arrhythmias in the absence of electrocardiograms.

One of the most common arrhythmias, especially in children, is sinus arrhythmia. This is an alternate slowing and acceleration of the heart beat usually synchronous with the phases of respiration. It is not an evidence of any heart disease and does not require treatment. It can be readily recognized by observation of the alternate increase and decrease of the heart rate with respiration and of its disappearance after mild exertion.

At times, a rate of 50 or lower per minute is encountered in normal individuals, in those convalescing from infections, or in those with jaundice. This is a normal bradycardia probably due to an increased vagal tone and should not be confused with the slow rate of heart block. Auscultation reveals slow normal heart beats which gradually quicken under the stimulus of exercise, atropine and adrenalin.

On the other hand, a rate of 120 or over, with the beats coming in orderly fashion, is a normal

or sinus tachycardia. While this condition may accompany heart disease, it is the normal response of the heart to fever, exercise, emotion, anemia, shock, hyperthyroidism and many other affections. It is worthy of note that one distinguishing feature between normal tachycardia and abnormal tachycardia is that the latter is much more abrupt in its onset than the former. The treatment for normal tachycardia is directed toward the underlying cause and not toward the heart itself.

Probably one of the most common cardiac arrhythmias is that produced by premature contractions usually called extrasystoles. They are produced by impulses arising prematurely in various parts of the heart and are divided into auricular, nodal and ventricular types. They may be recognized by hearing a quick beat followed by a pause coming in a series of normal beats. There may or may not be a corresponding radial pulse beat. If the radial pulsation is absent, it is necessary to exclude heart block and this may be done by auscultation. If the contraction is heard then it is a premature beat, if no sound is heard then most likely it is heart block. This is not always true because the impulse may originate in such a position in the auricle that no sound is produced and a tracing will be necessary to settle the question.

There may be no symptoms from premature beats or this arrhythmia may cause both uncomfortable sensations and apprehension. They may be found by the examining physician. Patients sometimes complain of a thumping sensation in their chests as though the heart were turning over. They may complain of a stopping of the heart which probably corresponds to the compensatory pause following the quick beat.

The sensations produced by premature beats usually occur when the individual is at rest and may prevent sleep. Activity, both mental and physical, tends to dispel the symptoms.

Premature beats do not necessarily signify the presence of organic heart disease. They may be present for many years in a healthy individual without producing ill effects.

* One of a series of articles sponsored by the Committee on the Heart, Arkansas Medical Society.

The excessive use of tobacco or coffee has been credited with being the cause of premature beats, although it is questionable if either have much influence in this regard. Digitalis will produce premature beats. This fact is useful in digitalis administration as they signal the onset of toxic symptoms from the drug, and indicate its discontinuance. Where organic heart disease is absent, it is likely that premature beats are of neurogenic origin and may be regarded as functional. Conversely, when organic disease is present, they assume a special importance. Following acute coronary occlusion, they may presage the occurrence of ventricular fibrillation. In mitral stenosis, they may indicate the onset of auricular fibrillation.

The origin of premature beats is easily determined by the electrocardiogram. Clinically, one may be able to distinguish interpolated ventricular premature beats by the presence of three quick beats in a series of normal beats. The pause of the ventricular premature beat is longer than that of the auricular. Observation of the jugular vein sometimes reveals a large wave synchronous with the ventricular premature contraction. Nodal premature beats usually require a tracing for their recognition.

The treatment of premature beats depends on whether they are considered serious or not. Sometimes reassurance to the patient is all that is necessary. If they are persistent, quinidine sulphate in a dosage of one and one-half to six grains, three times daily, will restore normal rhythm. Other drugs which have been suggested in the treatment of premature beats are digitalis, one and one-half grains twice daily, tincture of belladonna, 10 drops three times daily, and potassium chloride, 15 grains three to four times daily. Premature beats associated with organic heart disease usually require no specific treatment. If they are due to digitalis administration they can be useful in governing the dosage.

Another common and important arrhythmia is paroxysmal auricular tachycardia. The characteristics of this arrhythmia are a sudden rapid and regular rate of the heart beat lasting varying lengths of time followed by a sudden return to the normal rate. During an attack the rate may be 150 to 250 beats per minute, but the quality of the sounds is normal. While it may accompany organic heart disease, it is more common in healthy persons. The sudden onset of paroxysmal tachycardia may follow any slight exertion or even an emotional upset. With the onset come a wave of faintness, general nervousness, and extreme apprehension. Dyspnoea and pain are

usually absent but in occasional instances patients have complained of anginal pain or have developed congestive heart failure. The latter, when organic heart disease, may supervene after an attack of tachycardia of short duration.

In a particularly prolonged or severe attack, the patient appears as one suffering from an acute coronary occlusion. However, paroxysmal tachycardia is rarely associated with acute coronary disease. Too, the heart following recovery from the attack, is normal when due to paroxysmal tachycardia.

The diagnosis during the attack is not especially difficult. If it is a first attack, the patient will be quite naturally apprehensive, otherwise he is not greatly disturbed, although the heart may be beating 200 per minute. The heart beat should be accurately counted for a full minute and then the patient should hold his breath, or exercise slightly. If the rate is unchanged, the paroxysm is most likely due to auricular tachycardia. Another clinical method of establishing the diagnosis is by means of massage of the carotid sinus. In paroxysmal auricular tachycardia, the attack can be almost instantly terminated by massage of this area.

Several methods of treatment may be effective in an attack. Such simple procedures as holding the breath, provoking vomiting, pressure on the carotid sinus or the eyeballs may be all that is necessary to restore normal rate. To these may be added swallowing cracked ice, mild exercise, or sedatives. If the attack does not respond to any of these, more strenuous measures may be employed such as digitalis (7½ to 10 grains) intravenously, or mechoilin (1/3 grain) hypodermatically. While this is a reliable vagal stimulant, it should be used cautiously. Digitalis probably is the best prophylactic if the attacks come often enough to require attention.

Auricular fibrillation, or *delirium cordis*, is both a common and important arrhythmia. The name has been applied since it was shown through electrocardiography that the auricles were constantly responding to impulses in too quick succession for the ventricles to respond. Consequently, the ventricular rate is four or five times less than the auricular rate. The ventricular beats are uneven in force as well as time and because all of the ventricular beats are not transmitted to the radial pulse, there is a discrepancy between the number of beats heard in the cardiac area and the number felt in the radial pulse. This state of the heart may be found particularly in rheumatic heart disease with mitral

stenosis, hypertension, hyperthyroidism and coronary disease. It may occur transiently or may remain permanently after having established itself. In hyperthyroidism it is commonly paroxysmal. It is quite common following an acute coronary episode. Sometimes it is present in otherwise normal hearts.

The important diagnostic points to be remembered are, a rapid heart rate, a gross irregularity of the pulse both in force and time, and a pulse deficit. The presence of mitral disease or hyperthyroidism helps clinch the diagnosis.

The effect of digitalis on auricular fibrillation is specific. It slows the ventricular rate and increases the output of the ventricular contraction by allowing greater filling during diastole. The fibrillation may continue, but the work of the heart is improved and compensation maintained. It seems best to use either a pill of the powdered leaf or some preparation for intramuscular use depending upon the emergency. The drug is administered until the therapeutic purpose is achieved and then a maintenance dose is given. Excessive slowing of the heart rate, coupling of beats, nausea and vomiting are signs of digitalis poisoning.

To stop the fibrillation quinidine is necessary. However, it is well to remember that while quinidine may restore normal rhythm, it can also cause embarrassing consequences. Thrombi of the auricles may be dislodged and coursing through the circulation may produce hemiplegia, pulmonary embolism or death.

There are two main types of heart block. One is the sino-auricular type which is rare, and the other is the auriculoventricular type which is common.

The latter may be divided into three stages. The first is delayed conduction time which represents the mildest form of a V block. This requires no treatment although the underlying cause such as hypertension, coronary disease, or rheumatic heart disease of course do. The second stage is partial block and is identified by the absence of a ventricular contraction followed by a pause which is shorter than two complete normal beats. This condition may signal digitalis overdosage. The third stage is complete block, or Stokes-Adams disease. This occurs when the ventricles and auricles beat independently of each other because of some obstruction to the transmission of impulses to the ventricle from the normal origin of the heart beat. The normal rate of ventricular contractions is 25-40 per minute, and this fact provides a definite diagnostic sign. At times there may be pauses

in the rhythm or slowing of the beat which inaugurate the syncope of Stokes-Adams disease. This stage of block is most frequently associated with coronary artery disease. Diphtheria and syphilis may be other fundamental causes. It should be remembered that the danger of heart block comes from the possibility of complete cessation of the beat rather than the production of congestive failure. Stokes-Adams paroxysms are prognostic of serious consequences. They may be slight and require little attention. If they become more frequent and intense, causing the patient to faint many times daily, adrenalin is the drug of choice .3 to .5 c.c., 1-1000 solution every two hours by hypodermic. This may also be administered in oil for more prolonged action. Ephedrine sulphate may be substituted with agreeable results.

This is a resume of the most important cardiac arrhythmias. It is by no means a detailed discussion which is prohibited by lack of space in the Journal.

RESOLUTION

RESOLUTION ADOPTED BY THE FIRST COUNCILOR DISTRICT MEDICAL SOCIETY, JONESBORO, ARKANSAS, OCTOBER 2, 1943

Whereas, it has come to our attention that our present State Health Officer is to relinquish his duties on November 15, 1943, to re-enter the private practice of medicine,

Therefore, Be It Resolved, That the First Councilor District Medical Society wishes to express its sincere appreciation of the untiring efforts of Dr. W. B. Grayson, our State Health Officer, during the past several years in his campaign to educate the citizenship of Arkansas in preventive medicine; for his absolute fairness to the profession in all his official duties; for his cooperation with every member of the medical profession, ever keeping a kindly attitude and friendly approach to all the problems of this office, and for his zeal in ever striving for a more efficient state health department.

Be It Further Resolved, That we wish to emphasize that Dr. Grayson re-enters the private practice of medicine with the esteem and best wishes of this entire councilor district, and that we send a copy of this resolution to Dr. Grayson and a copy to the Secretary of the Arkansas Medical Society.

J. H. McCurry, M. D., Secretary.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

UNTIL recently, primary carcinoma of the lung was regarded as a relatively rare type of cancer. We are now recognizing that it is one of the commonest forms of neoplasm. It has been discovered that around 10 per cent of all cancers originate in the lung, that this organ is surpassed only by the stomach as the most frequent site of beginning malignancy, and that approximately 15,000 Americans succumb annually to carcinomata that arise from lung structures, usually in the bronchi. Such stark statistics and the demonstrated fact that cancer of the lung, like pulmonary tuberculosis, can be found early by employment of readily available diagnostic facilities, provide all physicians with food for thought as they evaluate the chest complaints presented by patients, especially men, and particularly those past 40 years of age.

CANCER OF THE LUNG—A GROWING PROBLEM

There is a masquerading lung disease which often gives quarter for a short time before the fatal issue and whose actions, in many ways, may simulate those of tuberculosis.

Both diseases are unique for they masquerade as other acute or chronic conditions of the lung. In neither are symptoms reliable in the early stages. Both diseases are marked by a lack of early reliable physical signs. Both are unique since in the early stages a single X-ray film will usually show some abnormality. Again, they are one another because in spite of obscure clinical factors the diagnosis can be accurately made in a high percentage of cases. Lastly, there is a similarity between tuberculosis and this masquerading disease, cancer of the lung, as successful treatment depends to such a large degree upon early discovery.

However, the two diseases are different as regards the predominant age groups affected. Tuberculosis concerns principally the age groups between 15 and 40, whereas lung cancer usually affects those between the ages of 40 and 65. The diseases are totally different in respect to the matter of time. In tuberculosis, time plus rest is often a useful ally of the patient in regaining health. In cancer of the lung the element of time is always an enemy of the patient. Prolonged observation and rest treatment never improve the situation, but rob the patient of his only chance for possible cure.

In 165 cases of lung cancer it was found that they first consulted a doctor because of symptoms usually associated with almost any chronic chest condition. A review of these symptoms suggests it would be impossible to set apart any group of complaints that could be regarded as pathognomonic of pulmonary malignancy. Nevertheless, 82 per cent of all the patients reported chronic cough, while no less than 92 per cent had as a first symptom something that called for attention to be directed to the chest when first the physician was consulted. Besides cough, other common symptoms included chest pain, chills and fever, hemoptysis, dyspnea, loss of weight and weakness.

Reviewing the physical signs elicited it is again impossible to outline a specific and significant grouping any more suggestive of cancer than of other chronic pulmonary conditions. Cases examined in the early stages often presented no physical signs. When present, the signs were of considerable variety and frequently misleading. They included evidence of congestion, consolidation, fluid, localized emphysema, cavitation, bronchial obstruction, mediastinal shift and other phenomena varying with the case, thus emphasizing the unreliability of simple physical signs in the differential diagnosis of this condition.

Of the 165 cases, 104 (63 per cent) were incorrectly diagnosed by the first doctor consulted. In view of the confused picture of misleading

symptoms and physical findings, perhaps this majority in favor of error is not completely surprising, but the sobering thought emerges that treatment based upon an erroneous diagnosis was maintained for long periods of time, aimed at such supposed conditions as tuberculosis, 40 cases; unresolved pneumonia, 18 cases; lung abscess, 13 cases; bronchitis, 11 cases; asthma, 5; heart disease, 4; pleurisy, 4; metastatic tumors, 2; and miscellaneous, 9 cases. Most notable fact was the high frequency of false diagnoses of tuberculosis.

Unfortunately, lung cancer was not unmasked in far too many cases until long after the patient first visited a physician. It was possible in 125 case histories to determine how speedily a verified diagnosis was reached. Two facts stood out boldly. First, 36 per cent of the patients placed themselves under medical supervision at onset or within one month of the onset of symptoms. Second, the average patient consulted a doctor within three months of onset but did not receive benefit of a chest X-ray for an additional three months. The true diagnosis was not arrived at until nine months had elapsed from the time when the first doctor saw the patient.

The X-ray, without doubt, is by far the most valuable aid in apprehending pulmonary disease, but a distinction is necessary between its ability to yield presumptive and absolute evidence. In 98 per cent of this series of cases the initial film revealed trouble was present. An explanation of the delay in reaching a final diagnosis may be found in the fact that in the majority of instances the primary pathological process failed to produce upon the film or the fluoroscopic screen a shadow of itself. Those abnormalities that did appear were secondary effects due to the presence of the neoplasm and were of such variability as to be susceptible of a wide range of interpretation.

In 95 per cent of the cases it was possible to establish an unequivocal diagnosis during life, bronchoscopy being the leading method of obtaining tissue, and having been employed in 103 cases. In 39 other cases surgical exploration was used. Metastases were sectioned in a few cases, aspiration was the method in another small group, while the remaining 5 per cent were diagnosed only after post-mortem examination.

For a decade surgery has been available in the treatment of lung cancer. A creditable showing has been made during this pioneering period. For example, 2 out of every 5 cases

surgically explored have been found to be free of extension of the cancer extrapulmonarily. The percentage of the entire group of verified cases for whom there was some hope of cure was 20 per cent. This seems an encouraging ratio when we recall that prior to 1933 there was no reason to regard the condition as anything but incurable. As a reward for our efforts, 20 patients, or 13 per cent, remain as the net salvage from the entire series of 156 verified cases of primary lung cancer, out of 32 individuals selected for an attempt at curative resection. These 20 patients are all reasonably well and devoid of evidence of metastatic disease, while five of them can be referred to as "cures" in so far as they have now passed the five-year mark.

In considering practical steps toward bringing cases of lung cancer to light during their curable stage we can learn valuable lessons from the record on tuberculosis case finding. Physicians have been taught that if tuberculosis is to be discovered during its minimal stage it is necessary not to search for absent or insignificant symptoms and physical signs but to go immediately to the X-ray. The same can be said for the apprehension of early lung cancer.

How may the first doctor consulted set in motion this mechanism of early discovery? He may save valuable time for his patient if he remembers:

1. That cancer of the lung is now one of the most important diseases of the chest in patients within the age period from 40 to 65 years, particularly in males.
2. That many patients do seek help at a time when the lesion is still confined to the lung.
3. That symptoms and signs are either lacking or misleading in the early stages.
4. That the earliest lesions will in almost every case produce some telltale shadow on the X-ray film, and
5. Finally, that there are two methods available for clinching the diagnosis:

First, that the majority of lesions are visible bronchoscopically and accessible for biopsy, and second, that when the suspicion cannot be verified in this way, it is possible to explore the chest safely by surgical means, settle the diagnosis and carry out curative treatment if necessary.

A Common Masquerading Lung Disease, Richard H. Overholt, M. D., *Diseases of the Chest*, May-June, 1943.

THE JOURNAL

OF THE

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W. R. BROOKSHER, M. D., Editor
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EDITORIALS

SOME COMMENTS ON THE WAR AND MEDICINE

R. B. ROBINS, M. D.
Camden

The medical corps means a great deal in the maintenance of the morale of soldiers. It is a great satisfaction to the soldier to know that if anything happens to him he will have expert medical care immediately. The sick and wounded soldiers are receiving treatment much more quickly in this war than in any previous war because of mechanization of the medical department and because of rapid evacuation by the airplane. The statistics are showing that so far less than 1% of wounded soldiers admitted to the hospitals have died, whereas in World War I 7% of the soldiers admitted to hospitals because of wounds died.

Rapid evacuation and speedy treatment are not the only factors that have given such ex-

cellent results. There are many more factors such as the use of the sulfa drugs, the use of plasma, better methods of anesthesia, etc.

We have given around 60,000 physicians to the armed forces, but still we have no reason to complain because we have more doctors now in civilian practice than other countries. For example, Britain has one doctor to 2,500 people; Russia only one to 5,000 people, and we have one to 1,500 people.

America has led the world in medical science for a number of years and it appears that it will have to assume the role of leadership for many years to come. Admiral McIntire has said that perhaps one-third of the medical personnel will have to be kept abroad for some time after the war for medical reconstruction.

The medical schools of most of the world have been entirely disrupted and millions of people will look to America to provide doctors for them. No doubt after the war there will be thousands of students from other parts of the world who will apply to American medical schools for admission. American medicine will have a grand opportunity in the postwar period to bring about a spirit of international good will by doing everything in its power to bring good health to the rest of the world.

We should be interested in world health because this will be a much smaller world to us after the war. It used to be many days around the world, but now it is only a few hours from any airport. There will be much intercommunication between us and the rest of the world. Diseases that we have not been accustomed to will be brought to us. To date we have never been much concerned about such diseases as typhus, plague, yellow fever, Australian Q Disease, Mediterranean Eruptive Fever, Trench Fever and Japanese River Fever, but we must from now on concern ourselves about them.

We have reached our world leadership in medicine by the American way of practice while other countries were trying out socialized medicine schemes. We now have people like Senator Wagner and others who want to completely revolutionize medicine in America. It is up to the doctors of America who know what good medical practice consists of to exert themselves in combating such legislation as is proposed by Senator Wagner.

It seems ridiculous to take advantage of the absence of millions of young men who are now in service and pass such revolutionary social legislation. Our young men in service are muffled in expressing their opinions. Only recently

South Carolina medical students petitioned their representatives in Congress against the Wagner Bill. The Army and Navy authorities immediately ordered the members of the armed forces to cease their efforts in this activity, since no member of the armed forces is allowed to participate in any activity which has to do with government policy.

Fellow physicians, it is up to us on the civilian home front to fight for the American way of the practice of medicine while our buddies are away.

MATERNAL AND CHILD WELFARE PROGRAM RESUMED IN ARKANSAS

Following a recommendation of the Council, the Arkansas State Board of Health resumed participation in the Federal maternal and child welfare program during October. The Council's consideration of the program was deliberate and thorough, and is expressed in the following resolution:

"The Arkansas Medical Society expresses approval of the objective to provide adequate obstetric and pediatric care to the wives and infants of enlisted men.

"The Arkansas Medical Society does not approve the present regulations of the Children's Bureau, Department of Labor, for the reasons (1) it establishes a medical, nursing and hospitalization program under the control of the federal government, (2) it precludes assistance on the part of relatives or friends of the families of servicemen, (3) it establishes a mandatory, inelastic maximum fee schedule for professional fees and hospitalization regardless of the merits of individual cases and of the circumstances involved, (4) it places a third party, a federal agency, virtually in control of medical services and injects a third party into the relationship between patient and physician, and (5) it establishes the base for a much larger federally controlled medical care program to cover all classes of citizens.

"Members of the Arkansas Medical Society are free agents in this work; each physician to decide for himself under what conditions he is willing to give the indicated professional services."

The Arkansas State Board of Health has mailed each Arkansas physician a brief statement covering changes in operation of the revised plan now in effect. A copy of the full

plan may be obtained upon request to the State Board of Health.

As now in effect, the maximum amount of compensation for obstetrical services rendered by the physician is fifty dollars. This includes the sum of fifteen dollars for pre-natal care, divided into three dollars for the first pre-natal visit and two dollars for each of six subsequent visits. The delivery fee is set at thirty-three dollars with an additional fee of two dollars allowed for a postpartum examination six weeks following delivery.

It is to be particularly noted that the remuneration for services dates only from the actual filing and authorization for such services. The physician may make his own charges prior to date of authorization but he agrees not to make an additional charge over the allowed fee for all services rendered after the date of application. In the event the full service, as above outlined, is not rendered, the physician's fee will be reduced in accordance with services not rendered. Where postpartum or delivery complications which require additional treatment, the physician must provide these services without additional charge. Consultants may be called on a case and a schedule of fees is set up for their services. In no event, however, may the fee allowed a consultant exceed that allowed the obstetrician for full obstetric care.

Misunderstandings have arisen in the past in connection with this program largely because of unfamiliarity with the provisions of the program. Physicians are urged to write for a copy of the detailed plan and to advise themselves of its requirements.

CHRISTMAS LETTERS

With the approach of the Christmas season, the Journal calls attention to the fact that many of our colleagues will spend this Christmas in strange, new surroundings. Some will spend a long, listless day in Army or Navy stations; others will be in active combat theaters over the globe, experiencing the grim horror of actual battle.

There is not much that those of us at home can do to lessen their loneliness at this season of the year. Gifts would be of help but no gift can bridge the gulf of separation between this military doctor and his home. To bring him as much cheer and comfort as is possible, write him a letter! Write all you know a letter! Write a letter that will bring him pleasant memories of practice at home, of the faith you have in them,

how you are working to preserve the traditions they are fighting for, a letter that will give hope for the future.

This you can do in a letter to them.

If you do not know their addresses, the Journal will forward your letters.

EDITORIAL COMMENT

ADDRESSES WANTED

Due to frequent changes in station, the Journal finds it difficult to keep an accurate list of members now in service with the armed forces. All efforts to locate the following members have been unsuccessful. Should any reader have knowledge of their present addresses, the Journal will appreciate hearing from him.

Joe W. King, Helena
 W. T. Wilkins, Cotton Plant
 J. L. Ruff, Searcy
 H. W. Savage, Little Rock
 R. E. Smallwood, Hot Springs
 A. W. Thompson, Bentonville
 Vincent Mazzanti, Little Rock
 R. F. Hyatt, Little Rock
 H. D. Fowler, Little Rock
 B. Z. Binns, Monticello
 W. W. Chamberlain, Hot Springs
 T. D. Alford, Little Rock
 B. P. Briggs, Little Rock
 Frank M. Adams, Hot Springs
 T. L. Adair, Bald Knob
 V. M. Cox, Huttig
 Jas. W. Burnett, Texarkana
 Marvin B. Crow, Warren

COMMUNIQUE

To the Editor:

Please change my address from U. S. Marine Hospital to the Mobile War Housing Clinic, Blakely Island, Mobile, Alabama.

The new job is rather interesting in that it was set up at the request of the Mobile and Alabama Medical Societies by the U. S. Public Health Service, and we are to practice general medicine and surgery as any other private practitioner except that we are on salaries and our fees are collected in the name of the Clinic for its upkeep with the surplus, if any, going to the Mobile Housing Board.

Respectfully,

Wm. Bunch, Jr.

PROCEEDINGS OF SOCIETIES

The Southeast Arkansas Medical Society met in dinner session at McGehee October 18th. President Allbright discussed recent proceedings of the Council.

S. W. Douglas, Councilor.

The Howard-Pike County Medical Society met at Nashville October 7th for the following program: "The Sulfonamides," J. L. Roberts, Nashville. The Society adopted resolutions in opposition to the Wagner bill.

M. D. Duncan, Secretary.

The Pulaski County Medical Society was addressed November 1st by M. J. Kilbury, "Blood Pictures in Children."

Elizabeth Fletcher, Secretary.

The Sebastian County Medical Society was addressed November 9th by Maj. T. V. Urmey, "Idiopathic Ulcerative Colitis," and "Spontaneous Pneumothorax and Spontaneous Hemorrhagic Pneumothorax," Capt. V. O. Lief, both speakers of Camp Chaffee.

W. F. Adams, Secretary.

The Craighead-Poinsett County Medical Society met November 4th as dinner guests of Mr. Herbert Parker, who addressed the meeting on "Is Prescription Writing Becoming a Lost Art?" The motion picture "Blood Plasma" was exhibited.

J. H. McCurry, Secretary.

The First Councilor District Medical Society met in dinner session at Jonesboro October 21st for the following program: "Some Uses and Disuses of the Sulfonamides," Capt. Louis J. Benton, M. C., Walnut Ridge Air Field; "Practical Considerations in the Treatment of Early Syphilis," Capt. Harry M. Cohen, M. C., Walnut Ridge Air Field; "Roentgen Therapy in Infectious Conditions," R. H. Willett, Jonesboro; and "The Wagner Bill," P. W. Lutterloh, Jonesboro. Officers elected are: President, Earle D. McKelvey, Paragould; Vice-President, R. C. Shanlever, Jonesboro; and Secretary-Treasurer, J. H.

McCurry, Cash. The Society will next meet in Jonesboro during March, 1944.

J. H. McCurry, Secretary.

The Ouachita County Medical Society met in regular monthly dinner session at the Ouachita Hotel in Camden November 4th. The following speakers were on the program: "Heart Irregularities," O. C. Melson; "Blood Diseases in Children," M. J. Kilbury, both speakers of Little Rock.

R. B. Robins, Secretary.

MONOGRAPH ON LYMPHOGRANULOMA VENEREUM

Noteworthy contributions to the detection and differential diagnosis of lymphogranuloma venereum are those of Rake, McKee and Shaffer, who have cultivated the agent in the yolk sac of the embryonated chicken's egg and obtained concentrated suspensions of elementary bodies. In this manner a highly purified and specific antigen, known as Lygranum S. T. has been prepared which is rapidly supplanting antigens prepared from either human pus or mouse brain. These workers alone, and in collaboration with Dr. A. W. Grace, have used the yolk sac antigen for the complement-fixation testing of serum suspectedly infected patients. The specificity and sensitivity of this antigen (Lygranum C. F.) provides an additional means of detecting early cases of lymphogranuloma venereum.

In the course of investigations involving these tests, there accumulated at the Squibb Institute for Medical Research a considerable mass of information concerning the properties of the causative agent, the epidemiology and clinical aspects of the disease. To facilitate the work of investigators and teachers in this field, and perhaps to encourage the interest of potential investigators, practicing physicians and health officers, it was decided to compile and publish the information at hand. The result is a 32-page publication entitled Lymphogranuloma Venereum—a Monograph. The value of the book is enhanced by maps, charts and numerous illustrations in color.

The Monograph is available gratis to physicians and to public health officials, and will be a valuable addition to medical college libraries. Those who request copies should enclose their professional card or use their professional letterhead.

PERSONALS AND NEWS ITEMS

C. B. Dixon, formerly of Decatur, has located at Van Buren.

Capt. Frank M. Adams, Hot Springs National Park, is now stationed overseas with a station hospital.

Lt. E. R. Barrett, Jonesboro, is now stationed overseas with the naval medical corps.

Capt. Wm. C. Hays, Jr., Hot Springs National Park, is now stationed overseas.

Chas. L. Weber, Magnolia, now stationed overseas, has been promoted to captain.

Capt. Floyd S. Dozier, Wilson, is now stationed overseas.

John S. Aqar, Little Rock, now stationed overseas, has been promoted to lieutenant in the naval medical corps.

Jerome S. Levy, Little Rock, now stationed at Bushnell General Hospital, Brigham City, Utah, has been promoted to major.

Capt. Garland D. Murphy, Jr., El Dorado, is now on duty at the Lake Charles Air Base, Lake Charles, Louisiana.

Maj. Otis G. Hirst, Prescott, is now on duty with an evacuation hospital overseas.

Lt. J. L. Pickens, Bentonville, is now on duty with the air force at Altus, Oklahoma.

Lindsley F. Billingsley has moved from Russellville to Monticello.

T. T. Ross has been appointed acting state health officer.

M. C. Hawkins, Jr., Searcy, recently took postgraduate work at the Lahey Clinic, Boston.

Euclid M. Smith, Hot Springs National Park, has been promoted to lieutenant colonel.

Chas. W. Rasco, Jr., DeWitt, has been promoted to captain.

D. E. White has been elected a director of the El Dorado Kiwanis Club.

Ralph E. Crigler has been elected a director of the Fort Smith Kiwanis Club.

Maj. Carl C. Hanchey, DeQueen, is now on duty with a station hospital overseas.

Geo. B. Fletcher, Hot Springs National Park, recently took special work in New Orleans.

Capt. Louis S. Dunaway, Conway, is now on duty with the 94th Station Hospital at Camp Carson, Colorado.

W. B. Grayson has opened an office at 841 Donaghey Building, Little Rock, for practice.

Charles Finney, Fort Smith, has been promoted to major.

Capt. William McKinley Parker, DeValls Bluff, is now stationed with an evacuation hospital overseas.

Wm. Bunch, Jr., Fayetteville, is now on duty with the United States Public Health Service at the War Housing Authority, Mobile, Alabama.

Lt. Perry Dalton, Camden, is now on duty at the Naval Air Station, Corpus Christi, Texas.

Capt. Charles G. Leverett, Eudora, who has been stationed overseas, is now on duty at Station Hospital, North Camp Hood, Texas.

Joe W. King, Helena, has been promoted to captain.

Lt. M. W. Chastain, Bentonville, is now stationed at the Harlingen (Texas) Air Field, as flight surgeon.

Lt. Col. Warren W. Chamberlain, Hot Springs National Park, is now stationed at Don Ce-Sar Hospital, Saint Petersburg, Florida.

Lt. Philip T. Cullen, Little Rock, is now stationed at Kelly Field, Texas.

A. F. Hoge, Fort Smith, recently attended clinics in New Orleans.

Maj. Sam S. Kirkland, Van Buren, has been assigned as regimental surgeon, 377th Infantry, now engaged in desert maneuvers.

J. A. Martin has moved from Hoxie to Bald Knob.

Lt. Comdr. Chas. S. Paddock, Fayetteville, is now stationed at the Naval Air Technical Training Center, Memphis.

W. T. Wootton, Hot Springs National Park, was installed as President of the Southern Medical Association in Cincinnati, November 16th.

W. D. Easterling, Lake Village, now stationed at Fort Bragg, North Carolina, has been promoted to major.

F. J. Scully, Hot Springs National Park, has been elected Grand Master of the Second Veil, Grand Royal Arch Chapter of Arkansas.

The following were in attendance at the Cincinnati session of the Southern Medical Association: B. E. Barlow, Dermott; W. A. Craig, Eudora; R. E. Crigler, Fort Smith; C. P. Harris, Jonesboro; D. T. Hyatt, Little Rock; J. B. Jameson, Camden; I. F. Jones, Fort Smith; H. King Wade, Hot Springs National Park; S. J. Wolferman, Fort Smith; G. C. Wood, Grady, and President W. T. Wootton, Hot Springs National Park.

COMMUNIQUE

October 20, 1943.

To the Editor:

Your V-mail Random Thoughts received today. Of course it brought back memories of pleasant associations with Arkansas M. D.'s. I am especially glad to have a new joke, the hen-cow-cat one. Guess none of Earle Hunt's would pass the censor?

After a few months in the jungles of * * * our * * * field hospital is thoroughly appreciative of this Shangri-La country, the mountainous scenery, ideal climate, friendly people and abundant food. The enemy air force provides plenty of excitement. So far, the victories have been ours!

Our hospital, * * * beds, is a very mobile one, arranged to split up into smaller units. We have attractive * * * female nurses. The morale of our enlisted men is excellent and I am proud to be in command of such a unit.

* * *

Best regards to friends in Fort Smith.

Sincerely,

Robert H. Johnston, Major, M. C.

RANDOM THOUGHTS OF THE SECRETARY

October 21st. Traveling to Jonesboro this afternoon, the company of Earle Hunt adding to the general enjoyment of the day but puncturing a hole in the gas tank becomes a serious problem for solution. Pleading with a mechanic for its repair and paying well over overtime rates, we shortly visit with the Lutterloh's prior to the dinner meeting. To a good dinner and excellent program with the First Councilor District Society where Willett ably upholds the claims of roentgen therapists in the treatment of infection. Commendably the Society resolves on Grayson now giving up the trials of public life to enter upon those of private practice. Dazzled perhaps by its fame, the visiting Army officer suggests penicillin as a possible therapy for syphilis, making this beyond doubt the most expensive bit of medical care yet to be recorded. Fortunate to have Earle's good colored chauffeur which permits Earle to join us in our customary night time nap across Arkansas.

October 27th. Briefly comes Stanley Gates to visit relating some of the latest vicissitudes of Army life, among them being the order to make physical examinations of * * * German prisoners now confined here, yet this seems small labor in comparison with the task of the laboratory officer, who has had many, many thick malaria smears dumped into his office with the promise of many, many more to follow. And so meditating that after all some medical officers do work, we go forth to take our part in the Selective Service screening, thereby adding to the work of other medical officers in the days that are to come.

November 7th. For the first time in 3,000 miles of gas-rationed motoring, we take the family to Burns Gables. This proves no less an occasion to Host Burns since he provides our special chicken liver dish and all of us think of Jim Amis probably eating goon livers by now.

November 9th. Tonight the medical officers from Camp Chaffee present another excellent program, our enjoyment being heightened by participation of the roentgenologist, ever an event when we can get this group of ours to listen to a discussion on roentgenology. Goldstein remains busily engaged throughout in patting himself on the back, taking full credit for the attendance, the program and all that is good about the entire affair.

November 10th. Today Blair achieves a "hole-in-one" and carries the irrelevant heckling in good spirits.

November 12th. Professionally, visiting Fayetteville, another rare treat these days, and enjoying once again the Washington's hot rolls as we persuade Ruth Lesh to eat steak rather than a sandwich.

November 17th. Telephoning President Wootton of the Southern Medical in Cincinnati for congratulatory conversation and surprised to find that his duties as president keep him away from his room until the hour of 3:00 A. M. (E. S. T.).

WHAT DO YOU THINK OF THIS?

"The President's wife said she believed medical care should be provided in civilian life as well as in military centers."—Associated Press Report, address, Eleanor Roosevelt, National Geographic Society.

COMMENTS ON THE WAGNER BILL

"The health of Americans comes first. * * * To turn over three billion dollars to one man to dictate what shall be done about the public's health, is to bestow a power in Washington which isn't equalled even in these days."—Arkansas Democrat.

* * *

"And it being the considered opinion of this club that the bill itself is a wide departure from American principles. * * * Therefore, be it resolved, that the Business Men's Club of Walnut Ridge publicly express its disapproval of the measure. * * *"

* * *

"Our people would do well to remember the words of a famous writer: 'If a nation values anything more than freedom, it will lose its freedom'."—Forrest City Daily Times-Herald.

* * *

"Whereas, in the opinion of the membership, the proposals of this bill are contrary to the concept of our American way of life. * * * Therefore, be it resolved, that the Forrest City Rotary Club go on record as being against S. Bill 1161."

* * *

"It does not seem possible the free American citizens want a one-man medical system any more than they want a one-man government."—Forrest City Daily Times-Herald.

* * *

"If you get federal aid and money, you've got to take the regimentation that goes with it, and that is one thing we are fighting this war to end that sort of thing."—Camden News.

* * *

"To sum the whole thing up in a few words it is just the creating of another bureau with a politician at the head of it, for the purpose of regimenting the medical profession to tear down democracy."—The Daily Citizen, Searcy.

* * *

"There are those who think the government should supply everything but eternal life. At the same time, they complain of growing bureaucracy and taxation. They forget that our government is a political organization never intended to manage the personal or business affairs of its citizens. Shifting the responsibility of medical care to government would not simplify the health problems of the individual. It would add to them by the destruction of medical efficiency and further pyramiding of bureaucracy."—The Commercial, Pine Bluff.

OFFICIAL WARNS DOCTORS TO BE ON GUARD AGAINST DRUG ADDICTS

Physicians should be warned to be on guard when strangers approach them regarding narcotic prescriptions, H. J. Anslinger, Commissioner of Narcotics, Washington, D. C., advises in a letter to the editor of The Journal of the American Medical Association and published in its October 30 issue. The letter follows:

To the Editor:

Because of the shortage of narcotic drugs in the illicit traffic, drug addicts are calling on members of the medical profession looking for a "soft touch." This is the addict's term for a doctor who will write a narcotic prescription after listening to a plausible tale. Hundreds of such cases are coming to our attention.

A drug addict goes into a doctor's office and simulates a bad cough. He tells the doctor that the only thing that will help him is a drug, the name of which he has on a slip of paper. He shows the doctor this slip of paper, on which the word Dilaudid is written. He takes a chance that the doctor is unaware of the fact that this drug is a derivative of morphine. It is surprising how many doctors follow the addict's suggestion and write a prescription for Dilaudid.

In another racket the physician is imposed on in a rather unusual manner and generally writes morphine prescriptions for quantities ranging from thirty to eighty 1/4-grain tablets. The addict calls on a physician and says his wife is in the care of a nurse and enroute by train to join him; that his wife is in a very serious physical condition, necessitating the use of morphine. He says that the doctor has been highly recommended and that he wants him to take care of his wife on her arrival, place her in a hospital and perform an operation if necessary. The addict offers a retainer. He then alleges that his wife has just stopped off in a nearby city and is unable to proceed by train until a supply of morphine is obtained; that the nurse telephoned him that his wife's supply is exhausted. The physician writes a prescription for morphine, which the addict claims he will send to his wife by air mail. In some cases the doctor has been taken in by this story to the extent that he has retained a room in a hospital for a week until he realizes that he has been victimized.

When addicts find a notice of a doctor's death in an obituary column they sometimes call on the bereaved widow on the day following the death alleging that they are narcotic inspectors and

have come to take charge of the doctor's morphine stock.

Pharmacists are being deluged with forged narcotic prescriptions. Blank pads are stolen from doctors' desks by addicts. Several times we have referred to numerous thefts of physicians' bags containing narcotics. A doctor's bag left in a parked automobile near a hospital is invariably stolen by a drug addict.

Physicians are being imposed on with increased frequency. I know they are extremely busy during this emergency. They should be warned to be on guard when a stranger tries to induce them to write a narcotic prescription. Many of the drug addicts today tell us that they are obtaining narcotics to satisfy their craving by going to various physicians and simulating some serious physical ailment.

H. J. Anslinger,
Commissioner of Narcotics,
Washington, D. C.

COMMUNIQUE

To the Editor:

Many thanks for the V-mail service edition of "Random Thoughts." An excellent idea, so keep 'em coming.

Am thoroughly satisfied that the people here are not satisfied with the panel system of medicine here, as well as the doctors.

Keep plugging back there and if I can help give them the second barrel here in * * * let me know.

Sincerely,
Chas. L. Weber, Capt., M. C.



MEMBERSHIP ROSTER OF THE ARKANSAS MEDICAL SOCIETY, 1943

ARKANSAS COUNTY

*Davis, G. C. Gillett
 *Dickens, Homer DeWitt
 *Drennen, S. A. Stuttgart
 Fowler, Arthur Humphrey
 John, Milton C., Jr. USA
 John, Milton C., Sr. Stuttgart
 †Lumsden, C. A. DeWitt
 Rasco, C. W., Jr. USA
 *Swindler, E. B. Stuttgart
 *VanDuy, T. S. Stuttgart
 Wassell, C. M. USN
 *Whitehead, R. H. DeWitt
 Wilson, J. G. Keo
 Word, J. T. Sweet Home

ASHLEY COUNTY

*Atkinson, H. H. USA
 *Barnes, L. C. Hamburg
 *Burt, E. G. USA
 *Cockerham, H. E. Portland
 Cone, A. E. Portland
 Cope, R. L. Hamburg
 *Crandall, M. C. Wilmot
 Fletcher, G. W. Montrose
 Hawkins, M. C. Parkdale
 *Mask, D. L. Hamburg
 Mosley, J. H. Shreveport, La.
 Parker, J. L. Snyder
 Pool, C. S. Malvern
 *Regnier, W. A. USA
 Smith, D. V. Crossett
 Smith, M. L. Crossett
 Spivey, C. E. Crossett
 *White, E. O. Hamburg
 Wood, J. T. Crossett

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 Curry, W. J. Rogers
 Duckworth, F. M. Siloam Springs
 Estes, Neal D. Rogers
 Eubanks, F. G. Decatur
 Greene, L. O. Pea Ridge
 Gullledge, J. F. Siloam Springs
 Harrison, A. J. Springdale
 Highfill, E. J. Cave Springs
 Hodges, Guy Rogers
 Hughes, G. A. Siloam Springs
 Huskins, J. D. USA
 Love, Geo. M. Rogers
 McNeil, Clyde Rogers
 Moore, W. A. Rogers
 Peacock, A. L. Bentonville
 Pickens, James L. USA
 Pickens, W. A. Bentonville
 Scott, L. L. Siloam Springs
 Thompson, A. W. USA
 Thompson, J. S. Gravette
 Williams, J. R. Siloam Springs
 Wilson, C. S. Siloam Springs

BOONE COUNTY

Blackwood, J. C. Western Grove
 *Fowler, J. H. Harrison
 *Fowler, Ross Harrison
 †Fowler, T. P. Harrison
 *Gladden, J. G. Harrison
 *Jackson, Ulys USA
 *Kirby, H. V. USA
 Morrow, J. J. Cotter
 *Moore, W. T. Everton
 *McCoy, O. B. USA
 *Owens, D. L. Harrison
 Poynor, M. H. Harrison
 *Rust, M. E. Harrison
 *Thompson, James I. Yellville
 Watkins, W. L. Alpena Pass

BRADLEY COUNTY

Belcher, Charles D. USN
 Crow, Marvin B. USA
 Crow, Marvin T. Warren
 Crow, Merle T. USA
 Gannaway, C. E. Warren
 *Hunt, W. J. Warren
 Martin, Charles Warren
 Martin, Rufus Warren
 Reasons, W. B. Hermitage
 Roark, W. N. Hermitage

CARROLL COUNTY

Bohannon, J. H. Berryville
 Butt, W. A. Green Forest
 *Carter, A. L. Berryville
 Donaldson, C. W. Green Forest

The Roster of the Arkansas Medical Society has been placed in the center of this issue to permit its ready removal for filing.

John, J. F. Eureka Springs
 *McCurry, D. K. Green Forest
 Newkirk, W. H. USA
 Roberts, D. C. Berryville
 Webb, J. H. Eureka Springs

CHICOT COUNTY

Baker, E. E. Dermott
 *Barlow, B. E. Dermott
 *Barlow, E. E. Dermott
 *Bottoroff, M. K. Lake Village
 *Burge, J. H. Lake Village
 Clark, B. C. Lake Village
 Craig, W. A. Eudora
 *Douglass, S. W. Eudora
 Easterling, W. D. USA
 †Hutson, W. J. Eudora
 *Leverett, Chas. G. USA
 *McGehee, E. P. Lake Village
 *Thompson, J. A. Dermott

CLARK COUNTY

Barnett, J. R. Arkadelphia
 Bremer, J. P. Point Cedar
 Doane, S. N. Arkadelphia
 Jones, L. B. Arkadelphia
 McLain, J. T. Gurdon
 Norton, J. M. Arkadelphia
 Pate, J. N. Arkadelphia
 Reid, Joe W. Arkadelphia
 Townsend, Chas. K. Arkadelphia

CLAY COUNTY

Blackwood, W. J. Rector
 Clopton, O. H. Rector
 Futrell, J. B. USA
 Hiller, J. P. Pollard
 Jones, F. H. Piggott
 Latimer, N. J. Corning
 McGuire, J. E. Piggott
 Turner, W. E. USA
 Turner, W. E., Sr. Piggott

COLUMBIA COUNTY

Baker, J. J. Magnolia
 Carrington, H. K. USA
 Cooksey, W. P. Magnolia
 Horn, W. H. Magnolia
 Hudnall, E. T. Taylor
 Hunt, W. J. Magnolia
 Jones, T. H. Waldo
 Jordan, T. S. Magnolia
 Kitchens, H. M. Waldo
 Longino, G. A. Magnolia
 McLeod, L. F. Magnolia
 Rushton, J. F. Magnolia
 Smith, P. M. Magnolia
 Souter, T. E. McNeil
 Weber, Chas. L. USA
 Wilson, J. H. Magnolia

CONWAY COUNTY

Atkinson, George Morrilton
 Close, Edgar Jerusalem
 Etheridge, C. E. Morrilton
 Halbrook, J. H. Plumerville
 Hardison, T. W. Morrilton
 Mobley, H. E. Morrilton
 Scarlett, W. P. U. S. P. H. S.
 Williams, C. R. USA

CRAIGHEAD-POINSETT COUNTY

Alcott, George B. Weiner
 *Barrett, E. R. USN
 *Berry, W. E. USA
 *Blanton, M. E. USA
 Burge, H. G. Nettleton
 Cantrell, M. L. Marked Tree
 *Cohen, O. T. Jonesboro
 *Ellis, Ira W. Monette
 Faris, John C. USA
 Harris, Chas. P. Jonesboro
 Hartwig, C. D. Lake City
 Horner, E. J. Jonesboro

*Jones, J. K. Lepanto
 *Lutterloh, P. W. Jonesboro
 *McAdams, H. H. Jonesboro
 *McCurry, J. H. Cash
 *McDaniel, E. C. Tyrnza
 *McDaniel, L. H. Tyrnza
 Modelevsky, A. C. Jonesboro
 Moreland, W. H. Tyrnza
 Nisbett, Frank Brookland
 Overstreet, W. C. Jonesboro
 Pierce, J. O. USA
 Ramsey, J. W. Jonesboro
 Reagan, C. H. USA
 Shanlever, R. C. Jonesboro
 *Sloan, Ralph Jonesboro
 Smith, O. V. Trumann
 Smith, W. H. Bono
 *Stroud, E. J. Jonesboro
 *Stroud, H. A. Jonesboro
 *Stroud, P. T. USA
 Thorn, W. T. Marked Tree
 Tullis, A. M. Trumann
 Verser, Joe USA
 *Verser, W. W. Harrisburg
 *Willett, R. H. Jonesboro

CRAWFORD COUNTY

Bennett, B. L. Van Buren
 *Bruce, B. B. Alma
 Boomer, F. A. Van Buren
 Campbell, C. J. Mulberry
 Crigler, J. R. Alma
 Dixon, Chas. B. Van Buren
 Galloway, O. R. Alma
 Grant, S. C. Mulberry
 Kirkland, S. D. Van Buren
 Kirkland, S. S. USA
 Kirksey, O. J. Mulberry
 Savery, H. W. Van Buren
 †Young, L. G. Van Buren

CRITTENDEN COUNTY

Bond, S. D., Jr. Crawfordville
 Hare, T. S. Crawfordville
 Irby, J. T. Earle
 Matthews, J. H. Earle
 McVay, L. C. Marion
 Parker, A. C., Sr. Clarksdale
 Parker, A. C., Jr. Poplar Bluff, Mo.
 Purnell, R. L. Marion
 Ray, R. H. Earle
 Stevenson, B. M. West Memphis
 Watson, H. S. Earle

CROSS COUNTY

Barr, A. F. Cherry Valley
 Griffin, W. L. Cherry Valley
 Hickman, R. L. Hickory Ridge
 Longest, Ruffin Wynne
 Miller, J. S. Wynne
 Peterson, T. A. Wynne
 Price, Thomas USN
 Smith, R. S. Parkin
 Wilson, Thomas Wynne

DALLAS COUNTY

Cheatham, H. A. Princeton
 Estes, E. E. Fordyce
 Estes, S. J. Fordyce
 Lisenbee, A. M. Sparkman
 Taylor, J. E. M. Sparkman
 Ward, W. P. USA

DESHA COUNTY

*Biscoe, Gibbs Dumas
 *Hellums, J. H. USA
 Kimbro, C. H. Tillar
 *Leverett, Marion McGehee
 MacCammon, Vernon Arkansas City
 *Rands, H. A. Dumas
 *Smith, H. T. McGehee
 *White, R. F. McGehee

DREW COUNTY

Billingsley, Lindsey F. Monticello
 Binns, B. Z. USA
 Collins, A. S. J. Monticello
 *Dickens, Robt. D. USA
 *Gates, Stanley M. USA
 *Holder, J. B. USA
 Pope, M. Y. Monticello
 *Price, J. P., Jr. Monticello
 *Wilson, J. S. Monticello

FAULKNER COUNTY

Baldrige, Doris Alene Conway
 Baldrige, Max USN
 Brittain, W. L. Conway
 Brooke, H. C. USA
 Dawson, R. L. Bee Branch

† Deceased.

* Wife is Auxiliary Member.

Dickerson, C. H. Conway
Downs, J. H. Vilonia
Dunaway, E. L. USA
Dunaway, L. S. USA
Fraser, N. E. Conway
Glover, A. J. Guy
Hardy, H. B. Greenbrier
Harrod, George Conway
Henderson, G. L. Conway
Kitley, J. R. Mayflower
Lieblong, J. S. Greenbrier
Mabry, Tom Vilonia
McCollum, I. N. Conway
Pickett, B. E., Jr. Carrizo Springs, Texas
Pickett, Mary R. Carrizo Springs, Texas
Taylor, R. L. USA

FRANKLIN COUNTY

Bollinger, W. H. Charleston
Gibbons, W. H. Ozark
Jewell, I. H. Paris
Pillstrom, E. W. Ozark
Porter, W. C. Ozark

GARLAND COUNTY

Adams, Frank M. USA
Bieri, E. J. USA
*Black, T. N. Hot Springs
*Blackshare, W. M. Hot Springs
Bollmeier, L. N. Hot Springs
Bowman, M. B. USA
Boydstone, J. O. USA
Brewer, Howell USA
Browning, E. R. Hot Springs
Bucklew, H. H. USA
Burch, N. B. Hot Springs
Burton, F. M. USA
*Casada, B. F. Hot Springs
Chamberlain, W. W. USA
*Chesnutt, J. H. Hot Springs
Clardy, Floyd Hot Springs
Coffey, G. C. Hot Springs
†Collings, H. P. Hot Springs
Connell, W. H. Hot Springs
Diederich, V. P. Hot Springs
Ellis, Jack USA
*Fletcher, George B. Hot Springs
Garratt, C. E. Hot Springs
*Gray, W. E. Hot Springs
Herbert, Gaston A. USA
Jarrell, Foster Hot Springs
*King, O. H. Hot Springs
Klugh, W. G. Hot Springs
Lee, D. C. Hot Springs
Lutterloh, C. H. USA
Martin, L. G. Hot Springs
Moss, C. S. Hot Springs
*Nims, C. H. Hot Springs
Pate, C. N. Hot Springs
Porter, W. F. Hot Springs
Power, A. R. Hot Springs
*Proctor, J. M. Hot Springs
Purdum, E. A. Hot Springs
Raney, C. J. Hot Springs
*Reed, L. E. Hot Springs
Rowland, Driver USA
Rowland, J. F. Hot Springs
Scott, Jett O. USA
Scully, F. J. Hot Springs
Shebesta, Bessey H. Hot Springs
Short, Z. N. Hot Springs
Smallwood, R. E. USA
Smith, E. M. USA
*Smith, O. A. Hot Springs
Smith, W. K. Hot Springs
*Stell, J. S. Hot Springs
Stough, D. B. Hot Springs
Strachan, J. B. Hot Springs
Sullivan, A. G. USA
*Tarleton, F. S. Hot Springs
*Tribble, A. H. Hot Springs
Ulferts, U. R. USA
*Wade, H. K. Hot Springs
Wilkins, J. S. Hot Springs
*Wootton, W. T. Hot Springs
Wright, H. K. USA

GRANT COUNTY

Cole, C. F. Prattsville
Cole, John W. Sheridan
Cox, J. E. Rosston
Hope, O. W. Sheridan
Kelly, M. F. USA
Kelly, O. R. Sheridan
Kelly, R. M. USA

GREENE COUNTY

Blackwood, J. D. Jonesboro
Bridges, G. P. Paragould
Dillman, J. A. Paragould
Ellington, W. E. Paragould
Haley, R. J., Jr. Paragould
Hudgins, J. J. Paragould
Hutcherson, R. L. Delaplaine

Lamb, J. W. USA
Lamb, W. M. Paragould
McKelvey, Earle D. Paragould

HEMPSTEAD COUNTY

Allison, W. G. Hope
Branch, J. W. USA
Cannon, G. E. Hope
Carrigan, P. B. Hope
Gentry, J. E. McCaskill
Heller, H. G. Hope
Holt, H. H. USA
Lile, L. M. Hope
Martindale, J. G. USA
McKenzie, Jim USA
Robins, W. F. Ozan
Smith, Don Hope

HOT SPRING COUNTY

*Barrier, W. F. Malvern
*Brown, H. L. Malvern
*Hodges, W. G. Malvern
McCray, E. H. Malvern
*McCray, R. V. Malvern
*Prickett, M. D. Malvern

HOWARD-PIKE COUNTY

Alford, T. F. Murfreesboro
Burlison, J. J. Antonine
Dean, L. A. Dierks
Dildy, E. V. Nashville
Duncan, M. D. Murfreesboro
Gould, W. B. Glenwood
Roberts, J. L. Nashville

INDEPENDENCE COUNTY

Barger, O. B. USA
Barnett, J. C. USA
*Bone, O. L. Newark
Brown, Harvey H. Independence, La.
*Cajaway, Hickman USA
Chambers, S. W. Mountain Home
*Churchill, C. A. USA
Copp, Noel Calico Rock
*Craig, M. S. Batesville
*Evans, L. T. Batesville
Gray, E. M. Mountain Home
Gray, W. Paul Batesville
Harris, C. L. Melbourne
*Hinkle, C. G. Batesville
*Jeffery, Paul Bethesda
*Johnston, O. J. T. Batesville
Jones, W. A. Los Angeles, Calif.
*Ketz, W. J. Batesville
Matthews, J. T. Heber Springs
*McAdams, V. D. Cord
*Monfort, J. J. USA
Robertson, S. N. Sulphur Rock
Roe, C. E. Viola
*Weddington, R. E. USA
Wood, O. S. Salem
*Wyatt, F. Q. Batesville

JACKSON COUNTY

Best, A. L. Newport
Elton, A. M. Newport
Erwin, I. H. Newport
Gray, C. R. Newport
Harris, M. L. Newport
Ivy, J. B. Tuckerman
Jamison, O. A. Tuckerman
Justice, S. Swifton
Kimberlin, K. K. Tuckerman
Norris, R. O. Tuckerman
†Owens, M. C. Newport
Pierce, W. N. Tupelo
†Stephens, G. K. Newport
Walker, H. O. Newport
Watson, E. L. Newport

JEFFERSON COUNTY

Beard, J. C. Pine Bluff
Binns, Van C. USA
Bruce, W. H. Pine Bluff
Capel, C. B. Pine Bluff
Capel, H. T. USA
Carruthers, C. K. Pine Bluff
Causey, H. A. USA
Clark, O. W. Pine Bluff
Cunningham, T. J., Jr. Pine Bluff
Cunningham, T. J., Sr. Pine Bluff
Garratt, A. A. Pine Bluff
Hames, Fred Pine Bluff
Hancock, W. G. Rison
Higinbotham, C. J. Pine Bluff
Jenkins, J. S. Pine Bluff
Lowe, W. T. Pine Bluff
Luck, B. D., Jr. Pine Bluff
Luck, B. D., Sr. Pine Bluff
Maynard, R. E. USA
McMullen, E. C. Pine Bluff
Palmer, J. T. Pine Bluff
Payne, Virgil Pine Bluff

Reid, Chas. W. Pine Bluff
Robertson, A. B. Rison
Russell, A. R. USA
Shelton, M. A. Wabbaseka
Simmons, Walter Pine Bluff
Snodgrass, W. A., Jr. El Dorado
Spillyards, J. S. Pine Bluff
Walker, J. K. Pine Bluff
Woods, R. P. Altheimer

JOHNSON COUNTY

Floyd, John Ozark
Graves, S. M. Mt. Levi
*Hardgrave, Geo. L. Clarksville
*Hunt, Earle H. Clarksville
*Johnston, R. H. USA
*Kolb, J. M. USA
*†Kolb, J. S. Clarksville
Pierce, S. C. Lamar
*Shrigley, Guy USA
*Siegel, G. R. Clarksville

LAFAYETTE COUNTY

Armstrong, R. L. Lewisville
Keith, A. W. Stamps

LAWRENCE COUNTY

Ball, C. C. Ravenden
Blaine, Mitchell Mammoth Spring
Brown, W. W. Hardy
Cruse, E. J. Black Rock
Elders, J. B. USA
Guthrie, T. C. Smithville
Faircloth, Robert S. Walnut Ridge
Hatcher, W. W. Imboden
Henderson, A. G. Imboden
Hughes, Max USA
Hull, H. B. Mammoth Spring
Jackson, J. F. USA
Johnson, T. Z. Walnut Ridge
Kendall, W. S. Cave City
Land, J. C. Walnut Ridge
Martin, J. A. Bald Knob
Merrell, J. L. Hoxie
Tibbels, C. D. Black Rock
Townsend, C. C. Walnut Ridge

LEE COUNTY

Bogart, H. D. Marianna
Chaffin, C. W. Moro
Crawford, W. S. Marianna
Hammer, J. H. Aubrey
Hodge, N. C. Marianna
McClendon, Mac Marianna

LINCOLN COUNTY

Bailey, B. L. Sterlington, La.
*Dixon, C. W. Gould
*Taylor, L. T. USA
Thiolliere, A. C. North Little Rock
Wood, G. C. Grady

LITTLE RIVER COUNTY

Engler, Frank G. Ashdown
Hamm, Patt Monroe, La.
Harding, C. A. Ashdown
†King, E. R. Ashdown
Peacock, Norman W. Ashdown
Yates, E. W. Foreman

LONOKE COUNTY

Beaty, S. S. England
Brewer, J. T. Kerrs
Callahan, E. A. Carlisle
Corn, F. A. USA
Crowgey, W. B. Scott
Southall, S. A. Lonoke
Ward, O. D. England
Watson, A. C. Benton
Wells, J. B. Scott
Whaley, E. S. Carlisle

MILLER COUNTY

Abrams, H. K. Texarkana
*Boone, R. F. Texarkana
Burnett, J. W. USA
*Daniel, N. B. Texarkana
Daubs, W. H. Foreman
*Frank, C. H. Texarkana
Fuller, T. E. Texarkana
Good, L. P. Texarkana
*Hibbitts, Wm. Texarkana
Hunt, Preston Texarkana
*Kirkpatrick, R. R. Texarkana
*Kittrell, T. F. Texarkana
*Kosminsky, L. J. Texarkana
*Lanier, L. H. Texarkana
Laws, C. S. Texarkana
*Lee, A. G. Texarkana
Lennard, F. M. Texarkana
Middleton, B. C. Texarkana
*Murry, H. E. Texarkana

Parson, G. W. ... Texarkana
 Robins, R. R. ... Texarkana
 *Smith, W. D. ... Texarkana
 *Tate, J. B. ... Texarkana
 Williams, J. F. ... Texarkana

MADISON COUNTY

Counts, G. D. ... Wesley
 †Hill, N. J. ... Hindsville
 Youngblood, Fred ... Huntsville

MISSISSIPPI COUNTY

Atkinson, G. S. ... Blytheville
 Beasley, J. E. ... USN
 Boyd, D. L. ... Blytheville
 Brownson, J. F. ... Blytheville
 Campbell, J. H. ... Marvell
 Dickerson, D. A. ... Marked Tree
 Ellis, N. B. ... Wilson
 Grimmett, W. A. ... Blytheville
 Harwell, C. M. ... Osceola
 Hassell, L. L. ... USA
 Hosey, N. R. ... Marvell
 Hubener, L. L. ... Blytheville
 Hudson, T. F. ... Luxora
 Husband, F. L. ... Blytheville
 Johnson, I. R. ... Blytheville
 Johnson, R. L. ... Bassett
 Mahan, T. K. ... USA
 Massey, L. D. ... USA
 Moseley, K. T. ... USA
 Owen, W. M. ... Armorel
 Polk, J. T. ... Keiser
 Robinson, A. F. ... Leachville
 Saliba, J. A. ... Blytheville
 Shedd, W. J. ... Osceola
 Sims, H. C. ... USA
 Skaller, M. L. ... Blytheville
 Stevens, C. C. ... Blytheville
 Tidwell, J. L. ... Dell
 Walls, J. M. ... USA
 Webb, Floyd ... Blytheville
 Wilson, C. E. ... Blytheville

MONROE COUNTY

Boswell, W. L. ... Clarendon
 Bradley, W. T. ... Blackton
 *Dalton, M. L. ... Brinkley
 Martin, W. H. ... Holly Grove
 *McKnight, C. H. ... Brinkley
 *McKnight, E. D. ... Brinkley
 †Murphey, N. E. ... Clarendon

MONTGOMERY COUNTY

Freeman, W. D. ... Mt. Ida
 McLean, J. H. ... Caddo Gap
 Stuart, J. B. ... Norman
 Watkins, G. E. ... Mt. Ida

NEVADA COUNTY

*Buchanan, A. S. ... Prescott
 Hairston, G. G. ... USA
 *Hesterly, J. B. ... Prescott
 Hirst, O. B. ... USA
 *Kennedy, J. W. ... Prescott
 McDaniel, T. W. ... Boughton
 Pool, W. B. H. ... Bodcaw

OUACHITA COUNTY

*Byrd, E. J. ... Camden
 *Clemens, J. P. ... Stephens
 *Dalton, P. J. ... USN
 *Early, C. S. ... Camden
 *Jameson, J. B. ... Camden
 *Kennerly, R. C. ... Camden
 *Magness, W. C. ... Camden
 *McGill, S. D. ... Camden
 *Partee, N. G. ... Camden
 Plunkett, C. M. ... Camden
 Powell, B. V. ... Camden
 Rhine, T. C. ... Thornton
 *Rhinehart, J. S. ... Camden
 *Robins, R. B. ... Camden
 *Robins, R. R. ... Camden
 Rushing, J. L. ... Chidester
 Thompson, H. F. ... Bearden
 *Thompson, S. A. ... Camden
 Thompson, S. B. ... USA

PHILLIPS COUNTY

Baker, J. P. ... West Helena
 Blackwood, J. O. ... USA
 Butt, J. W. ... Helena
 Connolly, W. B. ... USA
 Cox, A. E. ... Helena

Cox, A. W. ... Helena
 Dozier, F. S. ... USA
 Ellis, J. B., Sr. ... Helena
 Ellis, W. A. ... Helena
 Fink, M. ... Helena
 Herron, J. T. ... Helena
 Johnston, W. W. ... USA
 King, Jack ... USA
 King, J. A. ... Elaine
 King, J. W. ... USA
 King, W. C. ... Helena
 Kultgen, Edward ... Elaine
 Maddox, A. H. ... Elaine
 Nicholls, J. W. ... Helena
 Norton, E. F. ... Marvell
 Orr, W. R. ... Helena
 Rightor, H. H. ... Helena
 Ritchie, J. L. ... Helena
 Russwurm, W. C. ... Helena
 Storm, George R. ... Helena

POLK COUNTY

Campbell, C. A. ... Mena
 Hawkins, B. H. ... Mena
 LeFevers, R. R. ... Cove
 Lee, F. A. ... Vandervoort
 McElroy, F. Q. ... Mena
 *Miers, E. M. ... Mena
 *Redman, Pierre ... Mena

POPE-YELL COUNTY

Ballenger, W. E. ... Plainview
 Cowan, Riley ... London
 Gardner, Ellis ... State Sanatorium
 Grace, Kent ... USA
 Griffin, E. P., Jr. ... USA
 Hood, Robert ... Russellville
 Hornsby, W. W. ... Magazine
 Hoyt, Jonathan ... Dardanelle
 Hunt, E. C. ... Ola
 Millard, R. I. ... Russellville
 Montgomery, H. L. ... Gravelly
 Rushing, F. E. ... Russellville
 Sexton, J. W. ... Dover
 Smith, R. L. ... Russellville
 Smith, L. M. ... Russellville
 Stanford, J. M. ... Russellville
 Tate, A. B., Sr. ... Russellville
 Teeter, Brooks R. ... USA
 Young, W. O., Jr. ... Russellville

PRAIRIE COUNTY

Adams, Edward ... DeValls Bluff
 Calley, J. H. ... USA
 Gilliam, J. C. ... Des Arc
 Lynn, J. R. ... Hazen
 Parker, W. M. ... USA
 Porter, T. G. ... Hazen

PULASKI COUNTY

Aday, J. Leo ... USA
 Agar, John S. ... USN
 Alford, T. Dale ... USA
 Allen, H. R. ... Little Rock
 Allnutt, Grace C. ... Little Rock
 Anderson, C. C. ... Little Rock
 Anderson, P. R. ... USA
 Arkebauer, C. ... Little Rock
 Armstrong, H. M. ... USA
 Askew, J. B. ... Reno, Nevada
 Atkinson, Shelby ... North Little Rock
 Autry, D. H. ... USA
 Autry, P. G. ... Little Rock
 Banks, Jeff ... Little Rock
 Barrier, L. F. ... Little Rock
 Bennett, B. A. ... USA
 Bizzell, Ross ... Little Rock
 Blakely, R. M. ... Little Rock
 Blankfort, Gerald ... USA
 Boyle, R. M. ... Little Rock
 Briggs, B. P. ... USA
 Brooks, C. M. ... Little Rock
 Brown, Martha M. ... Little Rock
 Brown, T. D. ... USA
 Burgess, T. E. ... Little Rock
 Byrd, L. M. ... Little Rock
 Calcote, R. J. ... USN
 Caldwell, Robert ... Little Rock
 Carruthers, F. W. ... Little Rock
 Cazort, Alan G. ... Little Rock
 Champion, Jess Paul ... Little Rock
 Cheairs, D. T. ... Little Rock
 Chesnutt, C. R. ... Little Rock
 Choate, H. L. ... Little Rock
 Church, B. L. ... North Little Rock
 Clarke, A. S. ... Conway
 Clark, A. C. ... Little Rock
 Compton, J. N. ... Little Rock
 Coon, A. B. ... Little Rock

Cook, R. C. ... USN
 Cope, E. P. ... USA
 Cosgrove, K. W. ... Little Rock
 Crawford, J. B. ... Little Rock
 Cull, S. T. W. ... Little Rock
 Cullen, P. T. ... USA
 Cummins, Bryce ... Little Rock
 Cunningham, J. C. ... Little Rock
 Darby, Wm. J. ... Little Rock
 Darnall, R. F. ... Little Rock
 Davis, J. C. ... Little Rock
 *Day, E. O. ... Little Rock
 Dean, G. O. ... USN
 Dibrell, J. L. ... Little Rock
 Dibrell, J. R. ... Little Rock
 Dishongh, H. A. ... Little Rock
 Donaldson, J. K. ... USA
 Dykstra, D. W. ... U. S. P. H. S.
 Easley, E. J. ... McCombs, Miss.
 Eaton, John P. ... USA
 Eschweiler, Paul C. ... Little Rock
 Eubanks, R. M. ... Little Rock
 Fatherree, L. L. ... Little Rock
 Ferguson, R. L. ... Little Rock
 Fletcher, Elizabeth ... Little Rock
 Fowler, H. D. ... USA
 Freedman, Theo. ... Little Rock
 Fuller, H. L. ... USA
 Fulmer, D. W. ... USA
 Fulmer, P. M. ... Little Rock
 Fulmer, S. C. ... Little Rock
 Gann, Dewell, Jr. ... Little Rock
 Gay, E. C. ... USA
 Goodwin, Roy T. ... Little Rock
 Gray, A. F. ... Little Rock
 Gray, Oscar ... Little Rock
 Grayson, W. B. ... Little Rock
 Greutter, J. E. ... USA
 Hardeman, D. R. ... USA
 Harrell, W. B. ... USA
 Harris, F. W. ... Little Rock
 Harris, Thomas S. ... Bauxite
 Hayes, J. D. ... USA
 Hayes, J. H. ... Little Rock
 Henry, C. R. ... Little Rock
 Higgins, H. A. ... USA
 Hill, Harlan H. ... Little Rock
 Hollenberg, H. G. ... USA
 Hollis, N. T. ... Little Rock
 Holmes, G. M. ... Little Rock
 Holt, L. G. ... Little Rock
 Hoover, P. W. ... USA
 Hundley, John M. ... USN
 Hundling, H. W. ... Little Rock
 Hyatt, C. L. ... USA
 Hyatt, D. T. ... Little Rock
 Hyatt, R. F. ... USA
 Johnson, Glenn H. ... Little Rock
 Jones, H. Fay H. ... Little Rock
 Jones, J. E. ... Little Rock
 Junkin, Ruth ... Pine Bluff
 Junkin, S. P. ... Little Rock
 Kilbury, M. J. ... Little Rock
 Kober, W. M. ... USA
 Kolb, A. C. ... Little Rock
 Kolb, Agnes C. ... Little Rock
 Kolb, B. T. ... Little Rock
 Kory, R. C. ... Little Rock
 Lamb, W. A. ... Little Rock
 Langston, W. C. ... Little Rock
 Law, R. A. ... Little Rock
 Levy, J. S. ... USA
 Lewandoski, Martha S. ... Little Rock
 Lewis, G. V. ... Little Rock
 Lyons, V. E. ... USA
 Mahoney, P. L. ... Little Rock
 Martin, A. B. ... USA
 May, C. B. ... Little Rock
 Mazzanti, Vincent ... USA
 *McGaskill, M. E. ... Little Rock
 McClain, M. D. ... USA
 McLochlin, R. E. ... USN
 Melson, Madeline ... Little Rock
 Melson, O. C. ... Little Rock
 Moore, Rufus D. ... USA
 Morgan, Vern E. ... Little Rock
 Morgans, Dollie ... USA
 Morris, Harold ... Little Rock
 Murphey, Pat ... Little Rock
 Newman, W. V. ... Little Rock
 Nisbett, J. M. ... USA
 Nixon, Ewing ... USA
 Nowlin, W. A. ... Roland
 Oates, Chas. E. ... North Little Rock
 Parsons, J. E. ... Little Rock
 Parsons, W. R. ... USA
 Phillips, Sam ... USA
 Phipps, W. E. ... North Little Rock
 Raley, B. V. ... USN
 Raney, T. J. ... USA
 Reagan, G. W. ... Little Rock
 Reagan, L. D. ... Little Rock
 Reaves, B. J., Jr. ... Little Rock
 Reed, C. C., Jr. ... USA
 Reed, C. C., Sr. ... Little Rock

Rhinehart, B. A.	Little Rock
Rhinehart, D. A.	Little Rock
Rhyne, J. T.	Little Rock
Richardson, W. R.	Little Rock
Riegler, N. W.	Little Rock
Riggins, W. C.	USA
Ritchie, E. J.	USA
Roberts, J. N.	USA
Robinson, B. L.	Little Rock
Rodgers, Clyde D.	USA
Rosenbaum, Carl A.	Little Rock
Ross, T. T.	Little Rock
Rowland, R. E.	Little Rock
Sadler, W. L.	Little Rock
Samuel, John	USA
Sanderlin, J. H.	USA
Sanford, S. M.	USA
Savage, H. W.	USA
Saxon, R. L.	Little Rock
Schwarz, W. J.	Little Rock
Shipp, A. C.	Little Rock
Shipp, Harvey	USN
Shuffield, J. F.	Little Rock
Shukers, C. F.	USA
Slaughter, Pauline K.	Little Rock
Smith, H. H.	Little Rock
Smith, J. W.	USA
Smith, R. T.	Little Rock
Smith, W. M.	USA
Sparks, A. R.	Little Rock
Stathakis, John	Lincoln, Neb.
Stern, Howard S.	Little Rock
Stewart, H. V.	Milwaukee
Steinkamp, G. R.	USA
Stover, A. R.	Holbrook, Ariz.
Strauss, A. W.	Little Rock
Strauss, A. W., Jr.	Little Rock
Summers, J. A.	Little Rock
Switzer, D. M.	North Little Rock
Thomas, P. E.	Little Rock
Thomas, P. O.	St. Louis, Mo.
Thompson, E. I.	Little Rock
Thompson, G. D.	Little Rock
Thompson, Robert L.	Little Rock
Turnbow, R. L.	USA
Wallis, Chas.	Little Rock
Warden, J. R.	Little Rock
Washburn, A. M.	USA
Watkins, John G.	Little Rock
Watson, Asa C., Jr.	USA
Watson, C. F.	Little Rock
Watson, C. Robert	Little Rock
Wayman, A. K.	Little Rock
Wayne, J. R.	Little Rock
Webb, V. T.	Little Rock
Weny, N. F.	Little Rock
Whittier, R. W.	Little Rock
Wickard, C. P.	USA
Wilcox, L. A.	Little Rock
Wilkes, E. Hays	Little Rock
Young, R. G.	USA

RANDOLPH COUNTY

Baltz, M. A.	Pocahontas
Brown, J. W.	Pocahontas
Finney, C.	Maynard
Hamil, W. E.	Pocahontas
Loffis, J. R.	Pocahontas
Loffis, W. O.	USA
Ryburn, J. W.	Pocahontas
Smith, R. O.	Biggers

ST. FRANCIS COUNTY

Bogart, C. N.	USA
Burch, W. D.	Hughes
Caldwell, A. B.	Forrest City
Davis, Luther	Walnut Ridge
Davidson, J. S.	Forrest City
Lanier, Paul S.	Round Pond
McClendon, H. L.	Palestine
McCown, N. C.	Forrest City
Mohler, D. A.	Palestine
Roy, J. M.	Forrest City
Rush, J. O.	Forrest City

SALINE COUNTY

Ashby, John	Benton
Blakely, M. M.	Benton
Buffington, T. E.	Benton
Curtis, W. C.	Kerrville, Texas
Ellis, W. S.	Bauxite
Gann, Dewell, Sr.	Benton
Harrell, L. J.	Bauxite
Jones, C. W.	Benton
Ward, W. W.	Alexander
Walton, Chas.	Gulfport, Miss.

SCOTT COUNTY

†Bevill, Cheves	Waldron
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SEARCY COUNTY

Bing, E. A.	Marshall
Cotton, J. O.	Leslie
Daniel, S. G.	Marshall
Evans, P. L.	Marshall
Fendley, E. G.	Leslie
Hall, H. J.	Clinton
Leslie, J. O.	Marshall
Rogers, W. F.	St. Joe
Wood, E. W.	Marshall

SEBASTIAN COUNTY

*Adams, W. F.	Fort Smith
Amis, J. W.	USN
Arnold, W. O.	State Sanatorium
Benefield, C. E.	Fort Smith
Benefield, J. H.	Fort Smith
Billingsley, C. B.	Fort Smith
*Blair, A. A.	Fort Smith
*Brooksher, W. R.	Fort Smith
*Chamberlain, C. T.	Fort Smith
Coffman, J. S.	Lavaca
*Crigler, R. E.	Fort Smith
Curtis, A. C.	Little Rock
*Dickey, A. B.	State Sanatorium
*Dorsey, H. C.	Fort Smith
*Eberle, W. G.	Fort Smith
Evans, Martin M.	Fort Smith
*Finney, C. H.	USA
*Foltz, T. P.	USN
*Foster, M. E.	Fort Smith
*Goldstein, D. W.	Fort Smith
*Hall, C. W.	Greenwood
Henry, C. A.	State Sanatorium
Henry, Louise	Fort Smith
Henry, L. M.	USA
Hedrick, Rogers	USA
Hibbard, R. J. B.	State Sanatorium
*Hoge, A. F.	Fort Smith
*Holt, C. S.	Fort Smith
Holt, Ernest E.	State Sanatorium
Johnson, Hugh	Fort Smith
Johnson, J. D.	USA
Johnson, J. E.	Fort Smith
*Jones, I. F.	Fort Smith
Jones, E. B.	Hartford
*Kellum, J. L.	Fort Smith
Kennedy, C. H.	Fort Smith
*Krock, F. H.	USN
Little, J. E.	Wildcat Sanatorium
*McConnell, S. P.	Booneville
Means, C. S.	Fort Smith
*Moulton, E. C.	Fort Smith
Moulton, H.	Fort Smith
Nowlin, R. R.	State Sanatorium
Pride, Ben H.	USA
Redman, J. W.	Fort Smith
*Riley, J. D.	State Sanatorium
*Rose, W. F.	Fort Smith
Schirmer, R. E.	USA
Scott, M. H.	Fort Smith
*Smith, H. H.	Fort Smith
Shippey, W. L.	USA
*Southard, J. S.	Fort Smith
*Stevenson, J. E.	Fort Smith
Stocker, G. F.	USN
*Stubbs, S. P.	Fort Smith
Thompson, H. B.	Fort Smith
*Thompson, J. K.	USA
Waddell, Pearl B.	Fort Smith
*Ware, B. L.	Fort Smith
Wilson, C. L.	USA
*Wolfermann, S. J.	Fort Smith
*Woods, G. G.	Huntington
*Woods, W. M.	USA

UNION COUNTY

Atkinson, O. L.	Hampton
Cathey, A. D.	El Dorado
Cullins, J. G.	N. Chicago, Ill.
Cox, Vincent M.	USA
Fincher, L. G.	El Dorado
Harper, J. W.	USN
Irby, F. L.	El Dorado
Jones, Gus W., Jr.	USA
Jones, Kenneth G.	USN
Kennedy, C. E.	Smackover
Kitchens, D. K.	Detroit
Levine, David	El Dorado
Mahony, F. O.	El Dorado
Mayfield, H. F.	Huttig
Mayfield, H. J.	USA
McCall, Daniel	Lawson
McGraw, S. J.	El Dorado
McKay, Robert	Huttig
Mitchell, J. G.	El Dorado
Moore, B. L.	El Dorado

†Moore, J. A.	El Dorado
Munn, E. J.	El Dorado
Murphy, G. D., Jr.	USA
Murphy, G. D., Sr.	El Dorado
Murphy, N. A.	El Dorado
Muse, P. H.	Junction City
Newton, W. L.	Smackover
Patton, Doyle	USA
Pinson, J. H.	USA
Poole, Belle D.	El Dorado
Riley, W. S.	USA
Russell, M. V.	El Dorado
Sheppard, J. K.	USN
Slaughter, J. W.	El Dorado
Wharton, J. B.	USN
*Wharton, J. B., Sr.	El Dorado
*White, D. E.	El Dorado
Wozencraft, W. L.	El Dorado

SEVIER COUNTY

*Archer, C. A.	DeQueen
*Dickinson, R. C.	Horatio
*Hanchey, C. C.	USA
*Hendricks, J. S.	DeQueen
*Hopkins, R. L.	DeQueen
Jones, I. G.	DeQueen
*Kimball, G. L.	USA
*Kitchens, C. E.	DeQueen
Norwood, M. L.	Lockesburg

WASHINGTON COUNTY

Alexander, Gilbert	Muskogee, Okla.
Baggett, Jeff	Prairie Grove
Bean, J. L.	Lincoln
Bunch, W. L., Jr.	U. S. P. H. S.
Butt, W. J.	USA
Callen, C. B.	Fayetteville
Compton, Neil	USN
DeLaney, Jos. P.	Fayetteville
Ellis, E. F.	Fayetteville
Gibson, B. E.	Fayetteville
Gilbert, A. A.	Fayetteville
Gordon, Frank	Fayetteville
Hathcock, Alfred	USA
Hathcock, Preston	Fayetteville
Hathcock, P. L.	Fayetteville
Huntington, R. H.	Fayetteville
Leming, Howell E.	Fayetteville
Lesh, Ruth Ellis	Fayetteville
Lesh, V. O.	USA
Lewis, James F.	USN
Miller, R. W.	USA
Mock, W. H.	Prairie Grove
Paddock, C. S.	USN
Richardson, Fount	USA
Robinson, J. A.	Summers
Sisco, C. P.	Springdale
Sisco, Friedman	USA

WHITE COUNTY

Abington, E. H.	Beebe
Abington, W. H.	Beebe
Adair, T. L.	USA
Allbright, S. J.	Searcy
Burton, G. C.	Bald Knob
Dunklin, A. J.	Searcy
Emerson, A. G.	Bald Knob
Felts, W. R.	Judsonia
Hawkins, M. C., Jr.	Searcy
Hudgins, A. H.	Searcy
McAdams, J. C.	Russell
Mobley, Hugh	USA
Peeler, C. M.	Pangburn
Rector, Joseph L.	Tacoma, Wash.
Rodgers, P. R.	Searcy
Ruff, John L.	USA
Sloan, D. W.	Beebe
Sloan, J. R.	Garner
Sneed, J. W.	USA
Spain, A. L.	Letona
Wilson, W. H.	Griffithville

WOODRUFF COUNTY

Brewer, E. F.	Augusta
Dungan, C. E.	Augusta
Evans, R. H.	Chaffield
Hays, J. F.	Augusta
Maguire, F. C., Jr.	USA
Maguire, F. C., Sr.	Augusta
Morris, J. W.	McCrory
Murphy, Frank	Brinkley
Wilkins, W. T.	USA
Williams, W. J. B.	Cotton Plant

COMMUNIQUE

October 17th.

To the Editor:

Your bull-sheet arrived yesterday and all our gang enjoyed the hen-cow-cat story. Most of the names you mentioned are strangers to me, but there are a lot of Arkansas boys over here. Fount Richardson of Fayetteville is the C. O. of the hospital here and threw a big beer party for about twenty of us a few nights ago. The latest news I have of former Fort Smith doctors is that seven or eight of them are overseas, but the only one from anywhere near there that I have run across is Capt. W. L. Shippey. He's with a hospital at one of the airfields where I do occasional malaria inspections.

I believe I've told you before that I've been assistant theater malariologist for this theater since the first of May and also that I have finally got my majority, June 21st. The details of what we've done about malaria over here are still a military secret but I think it's allowable to say we did four times better than the most optimistic prophesy.

There's lots of tropical medicine to see over here. Amebiasis, cholera, smallpox, filariasis, tropical ulcers, etc., are every day sights. But malaria and bacillary dysentery are the most common. There's loads of lues and tuberculosis and plenty of such temperate zone ailments as pneumonia, diphtheria, meningitis, etc. There are lots of top-notch American doctors over here and they're really having a wonderful experience. And doing a hell of a good job, too, if anyone inquires.

Living conditions are pretty primitive at some of the jungle stations but here, in the beautiful city where the main American Headquarters are, is another story. Ten course meals, innerspring mattresses, personal bearers (valets), chota hayri (tea) in bed each morning, etc., are all routine. We'll all be terribly spoiled when we return home, won't we? There are four good movies here, several dances each week at the various * * * hotels, a number of good clubs and eating places, tennis, swimming, etc. There's even an * * * World Series baseball game on this afternoon.

The best news I have is that I'll soon be on my way home. In fact, there'll be no use of answering this letter, because I won't be here to receive it. I don't know yet where my new job will be in the States, but if I get a chance to visit Fort Smith, I'll surely take it. I would cer-

tainly like to see all of the old gang there again. It's two and a half years since I left and I suppose Camp Chaffee has caused many changes, not to mention the big flood.

Best wishes to all and be careful on that high flier stuff.

As always,
Charles H. Finney, Major, M. C.

COMMUNIQUE

To the Editor:

Have just received the July, 1943, issue of the Journal and wish to have delays like this avoided, so here is the new address * * *.

For the past twelve months have been serving in the Preventive Medicine Division of the Surgeon's Office here. The work is interesting and sufficient to maintain the attention of everyone. This Division of the Surgeon's Office has an epidemiologist, a medical inspector, a venereal disease control officer, a food and nutrition officer, and a sanitary engineer. It is an ideal set-up with all officers doing a good job. Our surgeon is a regular Army officer, and though all the others are from civilian life, they have learned the Army methods well.

Notice with interest in the Journal that the armed forces are still in need of medical officers. The American Armies' medical organization is surely more adequately organized for the care of the soldier than any other army in the world.

Attended quite an interesting talk the other day by a British surgeon * * *, who was a member of the Allied Medical Group that visited Russia for a study of their army and civilian medical services. * * *

We frequently have opportunity to attend Inter-Allied Medical Conferences in * * * where members of the medical profession from all the Allies meet and discuss problems of the war. The most interesting feature of these meetings is the meeting of medical men from all over the world and talking with them.

Our air force here, as you no doubt know, is causing the Germans plenty of trouble. It is the honor of this SOS to supply the services to them, which makes our work more interesting.

* * *

Yours truly;
Floyd S. Dozier, Capt., M. C.

COMMUNIQUE

October 8, 1943.

To the Editor:

It was a thrill to receive your "Random Thoughts" (Service Edition) this morning. It's fellows like you that help to make this job a little happier. The news is grand. It seemed that R. Cook wanted his picture in something. Why a half-submerged car? I saw Merle Woods in * * * three months ago, and his air corps is tops. He's a grand fellow, although still a captain after two years of duty. "M. D.s are only killed during pleasure rides." From over here I would suggest that W. B. Grayson have a chance to go to the town of Hindsville. Surely he won't object to working a little during the war. From what the papers say he is getting like that B-24 I saw the other day—singed-tail feathers. (Yep—he's my friend, too.)

This past year of soldiering is far from the life of Riley. Believe me the ground is pretty hard the first six months under a pup tent, dry or in the rain, but after that it becomes fun. I am the second oldest man in the * * * outfit. Even though we are mobile, we had to march sixteen miles in four hours before the Army would give us a truck. Yes, I'm still a captain. There must be something wrong with my personality. Anyway, I can't get my assistant a promotion even after fourteen months of soldiering. The reason is, "He can't command seventeen enlisted men!" What an Army, a first lieutenant with a wife and two children.

There are some mighty good stories over here, but censorship is tough. Remember, they didn't let anything out of * * * till Life and News Week came through. I am sure these and others will keep the home-front posted with all of the "H" hours and "D" days.

Doyle Fulmer, Capt., M. C.

COMMUNIQUE

To the Editor:

In regard to your request for an article on penicillin, I regret to say that the Surgeon General's Office is not allowing the medical officers working with penicillin to publish anything on the subject at the present time. I have made further inquiry since my last letter on the subject and find that they are quite strict on this subject. This is rather disappointing as we have an amazing group of cases which I would like very much to report in part in The Journal of

the Arkansas Medical Society. Suffice it to say that we have treated gonorrheal cases well into three figures with prompt and almost universally satisfactory results, and almost as many of the other miscellaneous sorts. Any acute type of infection caused by staphylococcus, streptococcus, pneumococcus, gonococcus and meningococcus responds brilliantly and immediately. We have had several cases of well-developed blood stream infection with multiple metastatic foci, all of which have recovered completely. The chronic conditions are responding more slowly than the acute ones and particularly where bone is involved and where there are foreign bodies in the form of sequestra, bullets or even extensive fibrosis. There are also some remarkably good results in actinomycosis. We have not had the opportunity to treat any clinically active gas gangrene, though several wounds contaminated with these organisms have been cleared of them.

I hope the production of penicillin will soon be greatly increased and that it will be available for all cases. It is so easily given by simple intramuscular injections and without any reactions or ill effects. We are happy to have been the first army hospital to utilize penicillin and have had an interesting time with this active penicillin ward and with many visiting officers here to observe.

I am enjoying the copies of the Journal sent to me and am particularly interested in the news of various individuals both at home and in the service.

Yours sincerely,

Henry G. Hollenberg, Lt. Col., M. C.,
Bushnell General Hospital,
Brigham City, Utah.

COMMUNIQUE

To the Editor:

The Journal has been reaching me through a circuitous route. This is my present address and I shall notify you of any change. I enjoy reading the Journal immensely, especially the "Random Thoughts" and the "Communiques." I have nothing to report other than that since graduating from the School of Aviation Medicine in July, I am still where the Battle of Texas is raging.

Faternally,

M. W. Chastain, Lt., M. C.,
Office of the Flight Surgeon,
Harlingen Air Field,
Harlingen, Texas.

WOMAN'S AUXILIARY NEWS

CHRISTMAS AND NEW YEARS

With the approaching Christmas holidays, we should realize how fortunate we are to be able to live in this wonderful country; to be able to celebrate Christmas; worship as we see fit, and to enjoy the many privileges this country of ours affords.

Many cities across the waters, whose skies are filled with deadly bombers, bring fear to helpless men, women and children, who tremble in underground shelters, while up to now, we can go about our daily tasks without fear in our hearts.

In this busy world of ours, we oftentimes are forgetful of all else but ourselves, yet at this season, praise and peace and love of fellow man should enter our hearts.

There is much to be done through our philanthropic program by our Auxiliaries, giving us the opportunity to share our joy and happiness with those less fortunate.

We do not know what the years ahead may bring but we pray that peace may soon come to the war-torn world and the message of the first Christmas, "Peace on Earth and Good Will to Men," be instilled in the hearts of mankind.

And as the New Year is close at hand, I trust every Auxiliary will tune up its forces and resolve to carry on with service to the community, state and nation, by furthering the program of the "Doctor's Aide Corps" and War Activities Committee.

May the Christmas and New Year's spirit fill our hearts with joy.

NETTIE F. KOSMINSKY, President.

The Woman's Auxiliary to the Sevier County Medical Society met October 12th at the home of Mrs. C. A. Archer, Mrs. Pierre Redman, President, presiding. A report of the State Board meeting was given. The Auxiliary voted to send Hygeia to the schools of the county. The following programs have been arranged: November, Hostess, Mrs. C. E. Kitchens; Mrs. L. J. Kosminsky, speaker; December, Hostess, Mrs. C. E. Kitchens; Mrs. Dickinson, leader, "Pioneer Doctors of Sevier County"; January, Hostess, Mrs. Tate; Mrs. Kitchens, leader, "Penicillin"; February, Hostesses, Mrs. Hooper and Mrs. Dickinson; Mrs. Hopkins, leader, "Public Health in Other Countries"; March, Hostess, Mrs. Hampson, program from dental magazine; April, Hostess, Mrs. Jones; Mrs. Hampson, leader, "Hygeia," and May, Hostess, Mrs. Hopkins, reports from State meeting.

MRS. C. A. ARCHER, Secretary.

Each member of the Sebastian County Medical Society Auxiliary will prepare a Christmas box for a Camp Chaffee station hospital patient it was agreed November 8th at the November luncheon meeting.

The women also voted to go to the Red Cross surgical dressing room to work after each meeting; and to contribute to the Earl Chambers Memorial Library Fund for the purchase of books for the Arkansas Tuberculosis Sanatorium at Booneville.

After the business session, conducted by Mrs. W. F. Rose, President, Mrs. W. R. Brooksher discussed briefly the organization and work of the Doctor's-Aide Corps.

Mrs. I. Fulton Jones and Mrs. J. S. Southard were hostesses.

COMMUNIQUE

To the Editor:

Please send me a facsimile of the Seal of the State Medical Society. I have ideas.

I notice that the Editor of the Journal did not have many thoughts in the August number of the Journal. My Congressman seems to be getting around. I have taken occasion to let him know my views on the federalization of medicine. I am interested in the "care of wives and children of enlisted men" in the August issue. It looks like bait. The public is going to be surprised some day at the cost and quality of medicine they receive. Looks like my threat to go back to the farm at Cane Hill is going to be called.

Bieri (Hot Springs), Pierce (Marked Tree), Maynard (Pine Bluff), Finney (Fort Smith), and Dalton (Siloam Springs), I have seen recently. Not bad for our state's showing.

Thanks for the Journal.

Fount Richardson, Major, M. C.

COMMUNIQUE

To the Editor:

Your letter of June 22nd finally arrived at the final destination which is at the present time somewhere in * * *. I haven't seen a copy of The Journal of the Arkansas Medical Society since leaving Fort Meade in the early part of 1943 and, believe me, I would and could appreciate seeing one now. I have not seen a M. D. from Arkansas since leaving Army and Navy at Hot Springs in August, 1942. Am anxious to hear from some of them and what they are doing out in the field and on the "home front." As for myself, I never felt better and "I have that old feelin' " it won't be long now! Let me hear from you.

Best wishes,

William M. Parker, Capt., M. C.

COMMUNIQUE

To the Editor:

* * *

Things over here are looking worse by the day for Tojo and his little yellow bellies. Our gang gave 'em a plastering a day right through the * * * except about six days. They are going to get it in a big way soon.

Regards,

Wm. L. Shippey, Capt., M. C.

COMMUNIQUE

To the Editor:

I am truly sorry that I have not been able to answer your request and letter of October 23rd, 1943. As you know, I just returned from overseas duty in the * * * Theater of Operations in August, after a year of quite wonderful, even though "rather warm" experiences. When I received your letter of October 23rd, it had been forwarded to three stations before I received it.

My permanent Army station and address is as follows:

Capt. Charles G. Leverett, M. C.,
O-345144,
Station Hospital,
North Camp Hood, Texas.

Very truly yours,
Chas. G. Leverett.

COMMUNIQUE

To the Editor:

Glad to note the news of all the gang from everywhere. Regards to Cook in Florida, McLochlin in Washington, and to all the rest. Greutter writes * * * is nice. By the way change my title from captain to major, as of last February. Henry Hollenberg continues to do his usual excellent work. Carrington was here—but now is? Bushnell Hospital has celebrated birthday No. 1 and the work done the past year is a credit to everyone. The penicillin work is outstanding. We think we are one of the best, if not the best, hospital in the country. Any bets, fellows?

Will be in Little Rock a few days next week and hope to see some of the gang as I did last August.

Best of luck,
Jerry Levy, Major, M. C.,
Bushnell General Hospital,
Brigham City, Utah.

The Sixth Annual Forum on Allergy will be held in the Statler Hotel, St. Louis, Missouri, on Saturday and Sunday, January 22-23, 1944. This is a meeting to which all reputable physicians are most welcome, and where they are offered an opportunity to bring themselves up to date in this rapidly advancing branch of medicine by two days of intensive postgraduate instruction. For instance, the fifteen study groups, any three of which are open to him, are so divided that those dealing with ophthalmology, and otolaryngology, pediatrics, internal medicine, dermatology and allergy run consecutively. In addition the study groups are arranged on the basis of previous registration. In this way, as soon as the registrations are completed, the registrant is expected to write the group leader and tell him just what questions he wants brought up in the discussion. Attention is also called to the fact that during these last two days almost every type of instructional method is employed. Special lectures by outstanding authorities, study groups, pictures, demonstrations, symposia and panel discussions.

COMMUNIQUE

To the Editor:

I have had a good rest since the close of the campaign in * * * and I am anxious to get over to * * *. I am feeling fine as I have been able to spend a lot of the past summer on the beach.

In two days I will have been in * * * eleven months and out of the States for 17 months. That is a long time but I am quite satisfied to stay over here until the whole show is over.

I enjoy reading the Journal and appreciate what the Society has done to make it possible for me to receive it.

I shall write another letter when I have something more interesting to write about.

Sincerely,
John M. Samuel, Major, M. C.

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BOOK REVIEWS

Rehabilitation of the War Injured: A symposium edited by Wm. Brown Doherty, M. D., and Dagobert D. Runes, Ph.D., rights reserved by Philosophical Library, Inc., New York. Printed by F. Hubner & Co., 1943.

This volume of six hundred and eighty-three pages, nicely printed, clearly indexed, but poorly illustrated is a collection of some fifty-five separate articles by different authors, many of whom are of considerable renown. The book strictly adheres to the matter of the war injured taking up a wide variety of subjects. The problem of psychiatry and the minor psychiatric conditions are considered. There is particular emphasis on the newer plastic procedures. Orthopedics receive very scant consideration as compared to its great importance in the war injured. Rehabilitation through physical therapy and occupational therapy and vocation are given the considerable importance they deserve. Some legal aspects of rehabilitation are presented in an interesting manner. The volume does not pretend to be a complete reference for surgical, medical, or psychiatric treatment, though it is up to date and presents many of the newer procedures and methods in these fields. It is of interest to those in the military service where definitive treatment is given. It should be of particular interest to any person dealing with veterans or discharged soldiers.

A Textbook of Medicine: Edited by Russell L. Cecil, A. B., M. D., Sc. D., Professor of Clinical Medicine, Cornell University Medical College; Attending Physician, New York Hospital; Visiting Physician, Bellevue Hospital, New

York City. Associate Editor for Diseases of the Nervous System Foster Kennedy, M. D., F. R. S. E., Professor of Clinical Neurology, Cornell University Medical College; Attending Physician, New York Hospital; Visiting Physician in Charge, Neurological Service, Bellevue Hospital; Consulting Physician, New York Neurological Institute. Sixth Edition, Revised and Entirely Reset. 1566 pages with 195 illustrations. Philadelphia and London: W. B. Saunders Company, 1943. Price \$9.50.

This standard text on medicine has been revised and includes new material on contact dermatitis, virus pneumonia, aviation medicine and other subjects not in earlier editions. In the laboratory tests value has been lent by mention of normal values. The sixth edition is worthy of the acclaim given the previous editions as a valuable text for the practitioner.

The Scientific Exhibit at the Chicago session of the American Medical Association, June 12 to 16, 1944, will be held at the Palmer House. Exhibits will cover all phases of medicine and the medical sciences with particular emphasis on graduate medical instruction for the physician in general practice.

Application blanks for space in the Scientific Exhibit are now available and may be obtained by communicating with the Director, Scientific Exhibit, American Medical Association, 535 N. Dearborn Street, Chicago 10, Illinois.

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No. 8

THE PROMOTION OF FRIENDSHIPS AMONG PHYSICIANS*

L. H. McDANIEL, M. D.
Tyrone

There is something better, grander, and more valuable to be received at our medical meetings than the new knowledge or new skill that we may acquire, although I would not have you think for one moment that I am minimizing the importance of the "brushing-up" and the "freshening-up" on new drugs, new treatments and new techniques that we obtain when we hear our brother physician report some new findings, new experiences or new successes that he has achieved. In the army this inexplorable and indescribable something is known as "morale." Surely the strengthening and reviving of our "morale" as a natural consequence of our medical society meetings is a prize that no physician should let slip by. Surely the failure to attend our medical society meetings exacts too heavy a penalty in the long run for the honest and sincere physician to have to pay. I hope you will not consider me overly sentimental when I tell you that I feel repaid for making the trip to the medical society when I receive the handclasp of my brother physicians and realize that there is a fellow-worker who struggles against the same problems which I experience, who knows the same joy and exhilaration that I know on the completion of a job well done, and one who has the same heartaches that I suffer when an All-wise Providence sees fit to write failure to a case in spite of our most heroic endeavors. We are told in that Great Book how the sinner received strength from touching the hem of the Master's garment. I mean no sacrilege when I tell you that your friendly handclasp does almost that much for me.

Last night I ran across a program of the Northeast Arkansas Medical Society for the meeting at Harrisburg, Oct. 17, 1929. Prominent on the

program were Dr. W. M. Majors, Dr. J. T. Altman, Dr. J. H. Lamb, Dr. Thad Cothorn, Dr. C. W. Garrison, Dr. G. A. Warren and others whose voices for honest and honorable medicine have been forever stilled and silenced and then I wondered if we as physicians are showing the proper appreciation to men such as Dr. McCurry, Dr. Verser, Dr. Stroud, and others whose medical careers should serve as an inspiration to the younger physicians.

"If with pleasure you are viewing
Any work someone is doing,
Tell him now!
Don't withhold your approbation
Until the preacher makes oration
And he lies with snowy lilies on his brow.

"For no matter how you shout it,
He will never know about it;
He'll not know how many teardrops you have shed.
So, if you think some praise is due him,
Now's the time to slip it to him,
For he cannot read his tombstone when he's dead."

Can't we express to our brother physicians both by word and deed our appreciation of him, beginning tonight?

While on the topic of friendships, the subject assigned to me tonight, will you permit me to give a description of a friend whom the Commencement Orator used the day I graduated from college, a description I often test in my mental classification of friends. May I dedicate this description to my friends, Drs. P. W. Lutterloh and Ira Ellis. I quote: "Oh, the joy, the unexplainable joy, of feeling safe with a person; having neither to weigh words nor measure thoughts—but pour them all right out—knowing that a faithful heart will take all, grain and chaff alike, keep those that are worth keeping and with the breath of love and friendship, blow the rest away."

When I think of the wonderful examples that my dear friends, Paul and Ernest Stroud, have before them constantly in the life and work of their father, I am reminded of another poem that I

*Read before the Craighead-Poinsett Counties Medical Society, January 7, 1943.

will read if Dr. Stroud will not think I am insinuating that he is getting old.

THE BRIDGE BUILDER

An old man going a lone highway
Came at evening, cold and gray,
To a chasm vast and deep and wide.
The old man crossed in the twilight dim—
The sullen stream had no fear for him;
But he turned when safe on the other side,
And built a bridge to span the tide.

"Old man," said a pilgrim near,
"You are wasting your strength with building here;
Your journey will end with the ending day;
You'll never again pass this way;
You've crossed the chasm deep and wide,
Why build you this bridge at eventide?"

The builder lifted his old gray head:
"Good friend, in the path I've come," he said,
"There followeth after me today
A youth whose feet must pass this way.
This chasm that has been naught to me
To that fair youth may a pitfall be;
He, too, must cross in the twilight dim—
Good friend, I'm building this bridge for him."

Gentlemen, this Society boasts of two physicians whose love for each other is a source of admiration and respect throughout the state. To watch these men struggle over a single penny in a game of chance or golf, knowing that they would gladly give each other many thousands of dollars gladly, if the occasion demanded, it is true entertainment. May I get personal and quote a poem that fits them:

THE TWO PALS

I called him John, he called me Jim,
Nigh fifty years that I knowed him
And he knowed me, and he was square
An' honest all that time, an' fair.
I'd pass him mornings goin' down
Th' road or drivin' into town,
An' we'd look up the same ol' way
An' wave a hand an' smile an' say:
"Hello, John,"
"Hi-rye, Jim?"

I guess you don't real often see
Such kind of friends as him an' me;
Not much at talkin' big; but, say,
Th' kind of friends that stick an' stay.
Come rich, come poor, come rain, come shine,
Whatever he might have was mine and
Mine was his'n, an' we both knowed it
When we'd hollow on the road:
"Howdy, John."
"Howdy, Jim."

An' when I got froze out one year,
He dropped in on me with that queer
Big smile an' layed two hundred dollars down,
An' says: "No int'rest, understand,
Er note." An' he took my hand

And squeezed it an' druv away,
'Cause there wusn't nothin' more to say.
"S'long, John."
"S'long, Jim."

An' when John's boy come courtin' Sue
John smiled an'—well, I smiled some, too,
As though things was a comin' out
As if we'd fixed 'em, just about.
And when Sue blushed an' tole me—why,
I sat and chuckled on the sly;
An' so did John—put out his hand—
No words but these, y' understand?
"Shake, John."
"Shake, Jim."

An' when Sue's mother died, John come
An' set with me, an' he was dumb
As fur as speech might be concerned;
But in them eyes of his there burned
A light of love and sympathy
An' friendship you don't often see.
He took my hand in his that day
An' said:—what else was there to say?—
"H'lo, John."
"H'lo, Jim."

Somehow the world ain't the same
Today. Th' trees are all aflame
With autumn, but there's something gone—
Went out of life, I guess, with John.
He nodded that old grizzled head
On the pillow of his bed,
An' lifted up the helpin' hand
An' whispered: "Sometime—understand?"
"Bye, John."
"Bye, Jim."

I fear that I have taken too much time with our poems and will save the complimentary verses on the other members until a later date.

I wish to tell you, ladies and gentlemen, a story originally told by Dr. Russell H. Conwell of Temple University, a story which he used as a central thought of a lecture, the proceeds derived from which he sent 1,265 boys through college; a story of a Persian farmer named Ali Hafed, who sold his farm, collected his money, left his family in charge of a neighbor and went away in search of diamonds. He searched all throughout Persia, then he came around into Palestine, then wandered on into Europe, and at last when his money was all spent and he was in rags, wretchedness and poverty, he stood on the shore of that bay at Barcelona in Spain, gazing out into space. When a great tidal wave came rolling in between the Pillars of Hercules, that poor, afflicted, suffering, dying man could not resist the awful temptation and he cast himself into that incoming tide and sank beneath its foaming crest, never to rise in this life again.

A few days later an old priest came in to visit Ali Hafed's successor and the moment that he

opened the door he saw that flash of light upon the mantel and he rushed up to it and shouted, "Here is a diamond. I know positively that this is a diamond." Then together they rushed out into that old garden and stirred up the white sands with their fingers and Lo! there came up more beautiful and valuable gems than the first. Thus, friends, was discovered the diamond mine of Golconda, the most magnificent diamond mine in all the history of mankind, excelling the Kimberly itself. My friends, there IS a diamond mine in and around every physician's office in Craighead and Poinsett counties, around every patient's home, in both counties, be it a mansion or be it a hovel, if you only choose to find them. With America trusting us physicians to keep the faith with our boys "over there" and "down under," can we afford to give anything but our best?

Now you ask me, "Why, Doctor, are you telling us this high school commencement story?" In just a moment I hope to make my point. Recently in going through the pages of a current magazine, I saw the pictures of five American Marines in a Jap concentration camp in Shanghai. I am passing this picture around and ask each of you to study it for a few moments. The Japs originally published this picture in one of their propaganda sheets and an American diplomat who was repatriated managed to smuggle it home. These men are Americans and most of them are not 30 years old in spite of their prison camp beards and mustaches. "Smile! Look happy"—one can almost hear the Jap photographer hissing the commands. And this was their reply—those faces you see staring back proudly, defiantly and a little contemptuously. Those faces could be duplicated by Drs. Reagan, Rush, Barret, Berry, Farris, Blanton, Paul Stroud, Jo Pierce, Joe Verser, and other physicians who belong to this medical society and who are now in our armed forces scattered all over the globe. Gentlemen, we must keep faith with those faces that I showed you. The best way we can keep faith is to look after these soldier boys' loved ones back home whether it be a humble home or a mansion in Cash, Jonesboro, Tyronza, or anywhere else.

A few nights ago, after a hard downpour, someone tapped at my front door shortly after I had retired after a busy day's work. Some ragged, wet and ignorant old man wanted me to go and see his wife whom he described as "mighty poorly." I almost refused the poor and penniless old man. My weary bones and the warm

bed cried loudly against the trip. The long trip, the bad roads, the wet, cold weather, each loomed up in my mind as obstacles too serious to tackle that night. But the pitiful tone of his voice, "Doctor, she is mighty poorly," overcame the temporary surrender to ease and rest and I grudgingly went. After some time I got to a hut that would have shamed almost an animal and rendered medical services to the best of my ability and before starting on the arduous return trip I struck up a conversation with the patient. I learned that this old lady who almost failed to get a physician to treat her for a case of pneumonia brought on by exposure had lost one son in action on the Solomons and another son was reported as missing following the fall of Corrigedor and is probably in a Jap prison camp. Gentlemen, this old woman has never been presented with a bill for that night's services, nor will she be.

He has not served who gathers gold,
Nor has he served whose life is told
In selfish battles he has won
Or deeds of skill that he has done.
But he has served who now and then
Has helped along his fellowmen.

COMMUNIQUE

December 3, 1943

To the Editor:

Really appreciated The Journal and the circular letters. From what I can figure out, the older boys at home develop more stamina as the years go by.

What kind of story did Foster have this year about the trout he missed in Colorado?

Received a recent letter from Ogden who is still in Long Beach, unfortunately undergoing a long convalescence from a serious abdominal operation.

Before returning home I had pleasant reminiscient sessions with Jack Ellis in..... and with Doyle Fulmer in.....

I've just completed a course in "How to Become a Pilot's Nursemaid," after serving a year in that capacity. In the interim, I have passed through a gratifying fleeting contact with medicine and surgery here at Kelly Field Hospital.

Best regards, and here's hoping that Foster, Eberle, Wolferman and McConnell do not deplete the bass supply of northwestern Arkansas.

Yours,
Wm. Merle Woods,
Capt., M. C.,
Station Hospital,
Kelly Field, Texas

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

IN the life of any individual the sudden spitting of blood is a dramatic and fear-stirring event. Usually it is brought to the attention of the physician so promptly that an accurate and rapid diagnosis is possible. Self-neglect, however, is encountered on the part of some patients. Errors in diagnosis, too, are not unheard of happenings. Thus there is every good reason why such an alarming symptom as hemoptysis must be viewed with concern by the doctor until the cause has been established and the proper emergency care and long-term treatment provided.

HEMORRHAGE IN PULMONARY TUBERCULOSIS

Pulmonary hemorrhage is one of the most distressing phenomena encountered in medical practice. The patient is gravely alarmed and the physician is confronted by bleeding that comes from a point deep within a delicate organ enclosed in a rigid framework. To combat the bleeding there may be only slowly or doubtfully effective physiological mechanisms.

Psychological effects to one side, hemoptysis generally is indicative of serious pulmonary disease. It is recognized that unexplained blood-spitting must be considered due to tuberculosis until proved otherwise. However, occasional causes include such nontuberculous diseases as bronchiectasis, bronchogenic carcinoma, lung abscess, rheumatic heart disease and various minor nose and throat affections. People apparently in good health and presenting negative physical signs and few or equivocal roentgen findings represent especially puzzling problems when they report having coughed up blood. In all cases it is essential that we exhaust every means at our disposal of tracking down the reason for obscure lung hemorrhage.

The causes of hemoptysis are still not clearly understood. Blame has been laid on deficiency in one of the factors concerned in blood coagulation, on tonic, nervous or endocrine factors, on erosion of a vessel wall by a tuberculous process, on rupture of a small aneurysm within a cavity. While the most serious hemorrhages occur in old, fibroulcerative tuberculosis, small or moderate hemoptyses may be seen in early disease, sometimes as the first recognizable symptom. Softening of a lesion or progression of an established process may be accompanied by hemorrhage.

Among 1,000 patients consecutively discharged from the Blue Ridge Sanatorium, Charlottesville, Virginia, only those were included in this study who gave a clear-cut history of spitting up one dram or more of blood, or who suffered a hemorrhage during their stay in the institution. "Streaking," "streaked sputum" and indefinite history of hemoptysis were excluded. In all, 905 cases of tuberculosis, made up of 424 males and 481 females, included 220 who had hemoptyses during the active phase of the disease. This is an incidence of 24.3 per cent, regardless of the duration of observation.

Some of the largest hemorrhages in this series occurred in a few patients showing bronchiectasis or rheumatic heart disease. Bogen, including instances of streaks and clots, found that over half of his hemoptysis cases expectorated less than two ounces of blood. The present study records 106 hemorrhages of stated amount, ranging from one dram to two quarts, the average being five ounces. This did not include repeated bleeding from the same individual on the same or subsequent days, since these were not felt to be distinct episodes, but more or less a continuation of the first. In approximately 40 per cent of the cases the episode of hemoptysis was repeated at least once.

Hemorrhage was the presenting symptom, often the initial evidence of trouble, in 60 cases. Perhaps nothing drives a patient to seek medical advice faster than the expectoration of a single mouthful of blood, although 23 patients did nothing about their initial hemorrhage.

When the local physician was consulted by per-

sons with hemorrhage in cases of previously undiagnosed tuberculosis 70 per cent were properly diagnosed, though it is estimated that 84 per cent correct diagnoses could have been reached by further study.

Only 49 cases in the entire hemoptysis group failed to show a cavity on X-ray examination and of these 11 were found to be nontuberculous. No less than 83.4 per cent of the tuberculous cases with hemorrhage had a positive sputum! Of the 170 patients in this latter category, 159 had roentgenograms revealing consolidation, honey-combing, punching out or frank cavitation.

Correlation of hemoptysis with physical exertion, with direct chest trauma or with mechanical disturbance of the lung is possible in some cases, though hemorrhage may and often does appear when the patient is at rest, perhaps during sleep. In only 28 cases in this study was there either a specific history of a precipitating factor or of its absence. In 10 patients hemorrhage was related to one or more menstrual periods.

Among the graver consequences of pulmonary hemorrhage must be listed strangling and asphyxia from massive bleeding, fatal blood loss in the cachectic patient, and the commoner and ever-present danger that blood from a cavity which is generating a positive sputum will spread the infection to other parts of the lungs, giving rise to an acute tuberculous bronchopneumonia or a massive caseous pneumonia. Obviously, repeated episodes of blood-spitting multiply the chances for such complications to occur.

Summary of Conclusions

1. In a study of 1,000 sanatorium tuberculosis patients it was found that hemorrhage occurred in 24.3 per cent of them.

2. The average size of hemorrhage was five ounces. Forty per cent of hemorrhages were eventually repeated.

3. In 60 patients, the first remarkable symptom was hemoptysis.

4. Seventy per cent of cases with a history of hemorrhage before diagnosis were properly diagnosed by the local physician, when he was consulted. However, 13 per cent were misdiagnosed.

5. Most tuberculous patients who hemorrhage have cavitation visible on X-ray examination; 83.4 per cent of this series had a positive sputum.

6. Trauma to the chest, strenuous exercise, mechanical disturbance of the lungs and, in females, the menstrual period are definite precipitating factors.

7. Small hemorrhages often occur from early lesions at the height of the catarrhal and toxemic

symptoms which probably signify softening. These are not usually serious and may, in the long run, be beneficial if they call attention to an undiagnosed tuberculosis. However, larger hemorrhages which occur in chronic ulcerative tuberculosis, while rarely immediately fatal, are accompanied by many unpleasant and dangerous possibilities. Of the 12 deaths which occurred in the sanatorium after hemoptysis, it is felt that 5 were directly or indirectly the result of the hemorrhage.

Hemorrhage in Pulmonary Tuberculosis, George R. Minor, M. D., American Review of Tuberculosis, August, 1943.

COMMUNIQUE

November 29, 1943

To the Editor:

Thanks for the seal. I presume it said "October 13th" and am proceeding on that basis. It was a little indistinct and may have read "October 18th." Correct me if I need it, though I haven't needed it for 15 or 20 years. Let's see, 1912, I think.

Ross Maynard's address is inclosed. Bieri and Pierce have changed stations. I think I can get them before this letter gets sealed. Shippey isn't near me but I hear of him. Finney will be home and give you some of the real dope. He hopes to go through Fort Smith. A Harkey, from Yellville, or vicinity, practicing in Detroit or Toledo, is with Maynard. The midwest and the southwest and North Carolina are plenty represented in this theatre.

* * * Believe me, the Democrats over here have it easy but the Republicans haven't even got shoes. Well, as a matter of fact, they do not need them but about two months of the year. * * *

So much for politics. The beautiful architecture and the beautiful flowers of..... are something to write home about. I have had the opportunity to visit two famous gardens and the coloring of the flowers in them gives the impression that the tint is packed in the flowers so that no more could possibly be put there. The fragrance of these plants gives the same impression. The architecture is no less impressive and is topped, of course, by....., in which you would not be disappointed.

Just now, however, the Ozarks would be most beautiful to me.

Fount Richardson,
Major, M. C.

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EDITORIALS

THE MEDICAL PROFESSION IN 1944

Increasingly of late years has it been necessary for the organized medical profession to combat trends inimical to the best interests of the public and of the profession. Currently there seems to be no end to the problems which present themselves and the leaders of our groups find it necessary to keep constantly on the alert against activities which would in effect destroy the very life of our noble profession.

The great burden of the fight against special interests and the like which would seek to make physicians the slaves of governmental or other authority, which would destroy the attainments of years in the establishment of standards of medical care unequalled throughout the world, falls upon the elected leaders of the profession. In fact, long ago was the day when election to leadership signified an honor to the physician so elected; rather, now does it indicate that by such selection the membership have indicated their confidence in the ability of the individual physician to successfully initiate and prosecute the fight of organized medicine against exploitation by selfish outsiders. The sacrifice in time, effort

and money by these leaders has been great, yet it is obvious that even greater sacrifices lie ahead. Our elected leaders are well aware that this will be required of them. As we enter into 1944, let us resolve that we will personally support, in fullest degree, the efforts of our leaders to maintain the American system of medical practice. We cannot do otherwise.

LEARN TROPICAL AND SUBTROPICAL DISEASE, CIVILIAN DOCTORS TOLD

American civilian physicians are advised by the Subcommittee on Tropical Diseases of the National Research Council to be familiar with the tropical and subtropical diseases that may be imported to this country by returning members of the military forces of the United States.

In a statement, approved by the Division of Medical Sciences of the National Research Council and the Surgeons General of the Army, Navy and Public Health Service and published in The Journal of the American Medical Association for December 18, the Subcommittee says:

"The military forces of the United States operating in tropical and subtropical areas are exposed to a number of diseases which occur only in those areas or are much more prevalent there than in this country. Some of these diseases will be brought back to this country in returning military personnel and may be seen by civilian practitioners of medicine either in persons infected abroad or in persons to whom the diseases have spread from the original cases. It is important that physicians be familiar with the diseases which may be imported, and that they be on the alert to diagnose and treat them correctly and to prevent their spread.

"Malaria is the most important of these diseases. In most tropical regions *Falciparum* malaria, the severe form of the disease, predominates. *Vivax* malaria is also common. *Malariae* malaria is relatively rare, and *ovale* malaria is very rare. Neither quinine nor atabrine prevents malarial infection. Suppressive treatment, formerly incorrectly termed 'drug prophylaxis,' will usually prevent clinical symptoms and keep infected persons on their feet as long as they continue such treatment, but many of them come down with clinical malaria within a few weeks after stopping treatment. Such cases are more likely to be caused by *Plasmodium vivax* than by *Plasmodium falciparum*. *Vivax* malaria is prone to relapse several times even after supposedly adequate courses of treatment. Some military and civilian personnel, returning to this country by air, become infected while stopping

in highly malarious areas en route. These persons have their first attack of malaria, usually falciparum infection, after arriving in this country. The symptoms may be obscure and the disease not suspected, and coma or even death may ensue before the diagnosis is made.

"Malaria should be suspected in every person returning from the tropics or subtropics. The disease may simulate almost any acute or chronic abdominal condition, upper respiratory or pulmonary conditions, meningitis, encephalitis, coma from other causes, or primary or secondary anemia. * * * Species identification should be made by a competent technician, and the disease should not be excluded until several blood examinations have been made at intervals of six to twelve hours. Vigorous treatment must be instituted promptly to avoid fatalities and to diminish the incidence of relapses.

"It is possible that local outbreaks of malaria may occur in this country, starting from relapsing cases acquired abroad. The United States Public Health Service recognizes this possibility, is already cooperating with certain states in intensive anti-mosquito programs and is prepared to act vigorously if epidemics occur. Physicians can cooperate in avoiding such occurrences by the early diagnosis and reporting of cases, by adequate treatment and by preventing access of mosquitoes to infected patients. * * *

"Individuals without clinical malaria but in whose blood malarial parasites are found should be treated immediately or kept under careful observation.

"Bacillary dysentery is usually an acute disease but may become chronic or give rise to carriers. Although the use of sulfonamide drugs will undoubtedly diminish the probability of chronic or carrier conditions, a history of the disease in military personnel should lead the physician to keep it in mind. The cause of chronic diarrhea or any vague abdominal symptoms should be investigated bacteriologically. Transient or chronic carriers of dysentery bacilli are usually present among the contacts of cases. * * *

"Amebic dysentery, or amebiasis, is much more likely than bacillary dysentery to become chronic or to recur in acute or subacute episodes. It may result in liver abscess even without previous noticeable symptoms. * * * The incubation period may be very long, or infections acquired in the tropics may produce no symptoms in the initial patient but may be responsible for family or community epidemics under conditions of bad sanitation or contamination of water supplies. Clinically amebiasis should be suspected in any

person returned from the tropics who complains of blood in the stools, alternating diarrhea and constipation or vague abdominal symptoms. * * *

"Filariasis, caused by *Wuchereria bancrofti*, the lymphatic filarial worm of man, is prevalent in many parts of the tropics, particularly in certain islands of the Southwest Pacific (the disease involves infection of the lymph glands, causing their enlargement and an inflammatory swelling of the affected parts). It is transmitted by a number of species of mosquitoes, the most important of which are probably *Culex quinquefasciatus* and *Culex pipiens*, the common night biting mosquitoes of both hemispheres. The incubation period of the disease is usually six months or longer. * * * There is no specific treatment for the worm, but sulfonamides sometimes relieve the lymphangitis, at least temporarily. * * *

"The other diseases which may possibly be brought into the continental United States by returning military personnel are visceral and cutaneous leishmaniasis (oriental sore), schistosomiasis (infection with the blood parasites, *Schistosoma*), the filarial worms *Loa loa* and *Onchocerca* (forms of filariasis), African trypanosomiasis (known as sleeping sickness in its later stages), leprosy, relapsing fever and various fungous diseases of the skin. The probability that new endemic areas of any of these diseases will become established in the United States is very slight. They should, however, be recognized clinically and etiologically by the medical profession.

"It is recommended that physicians and health departments prepare themselves for the diagnosis, treatment and control of disease brought back by returning military personnel. * * *"

ANNUAL CONFERENCE OF SECRETARIES AND EDITORS

The annual conference of state secretaries and editors was held in Chicago, November 19th and 20th with full attendance. Attention was devoted to the problems of state medical societies and full discussion was evoked. James E. Paulin, President, American Medical Association, discussed the postgraduate education program now in effect for members of the profession in military service and called attention to the need for a study of post-war problems. The need for an equitable distribution of physicians returning from military to civilian practice is a foremost task. Major General Lull, Deputy Surgeon General, spoke on the problems of assignment of physicians in the army medical corps, of the les-

sons military medical officers are learning, and of the need for post-war refresher courses. Dr. Victor Johnson, Secretary, Council on Medical Education and Hospitals, American Medical Association, discussed the present accelerated program of medical education. President-Elect Herman Kretschmer asked that all physicians devote study to the Wagner bill and that they bring these provisions to the attention of their patients and associates. Procurement and Assignment Service problems were presented by Dr. Harold S. Diehl, Directing Board. Dr. Walter F. Donaldson called for greater activity in the state societies for the Committees on War Participation and suggested possible activities for these committees. Dr. Louis H. Bauer, Secretary, Council on Medical Service and Public Relations, presented the functions and efforts of this new council. Mr. J. W. Holloway, Jr., Bureau of Legal Medicine and Legislation, analyzed present legislation in Congress. Discussion of the MCH program of the Children's Bureau was especially free and representatives of the various state societies gave resumes of their relationships under this program.

ARKANSAS PROCUREMENT AND ASSIGNMENT SERVICE POSITION AT PRESENT

Some confusion exists in the state over the need of the military medical forces for additional physicians. It seems generally understood that Arkansas does not have a quota to fill at this time. This is correct, yet it must be further understood that Procurement and Assignment Service is not now operating solely on a state quota basis. The Army and Navy are still in great need of physicians, and while Arkansas has filled its assigned quota, it is desired that further consideration should be given to the remaining physicians within the state who could be declared available without producing a distress area in their respective communities. Arkansas has been asked, therefore, to continue to declare as "available for military service" those physicians in the suitable age group, professionally and ethically qualified, who can be spared from civilian medical practice. The effort to secure additional medical officers is continuous throughout the country and seeks to secure not only those available physicians not previously declared available, but to review the physical status of physicians who have been previously rejected for appointment because of minor physical disqualifications. The cooperation of all is requested in a continuation of the effort to supply needed medical officers for the armed forces.

PROCEEDINGS OF SOCIETIES

The Ouachita County Medical Society met in regular monthly session December 2nd at the Camden Hospital. Dr. T. E. Rhine, the retiring president, was host at a dinner for the members. The program consisted of the following motion pictures:

"Continuous Caudal Anesthesia in Obstetrics,"
"The Singer Surgical Needle and Suturing Technique."

The following new officers were elected: President, J. L. Rushing, Chidester; Vice-President, W. C. Magness, Camden; Secretary, R. B. Robins, Camden; Delegate, R. C. Kennerly, Camden; Alternate, J. P. Clemens, Stephens.

R. B. Robins, Secretary.

Members of the Craighead-Poinsett County Medical Society and of the Auxiliary were entertained at a dinner in Jonesboro recently by Dr. and Mrs. P. W. Lutterloh. The following officers were elected: President, Ira W. Ellis, Monette; Vice-president, W. H. Moreland, Tyronza; Secretary-treasurer, J. H. McCurry, Cash, and member, Board of Censors, R. C. Shanlever.

J. H. McCurry, Secretary.

The Ninth Councilor District Medical Society met in luncheon session at Harrison December 8th. The following program was presented: "Torson of Ovarian Cysts in Children," Ruth Ellis Lesh, Fayetteville; "Perforated Peptic Ulcer," F. T. H'Doubler, Springfield, Missouri; "Immunization Procedure," U. J. Busiek, Springfield, Missouri; "Pyelitis," W. S. Sewell, Springfield, Missouri, and "The Physiology and Mechanism of Labor," W. A. Fowler, Fayetteville.

OBITUARY

MOSES GREEN DALY, age 68 years, Little Rock, died December 12th. Born in 1879, he graduated from the University of Arkansas School of Medicine in 1912 and had continuously practiced his specialty of anesthesia since that date in Little Rock. In addition to his membership in the Pulaski County Medical Society and the Arkansas Medical Society, he was a member of the Second Baptist Church, of the various Masonic bodies and of Scimitar Temple. Surviving him are his wife and a son.

PERSONALS AND NEWS ITEMS

Capt. Barney P. Briggs, Little Rock, is now stationed at Sheppard Field, Wichita Falls, Texas.

R. J. B. Hibbard, State Sanatorium, has been appointed superintendent of the Utah State Tuberculosis Sanatorium, Ogden.

Ben H. Pride, Fort Smith, now stationed at Tarzana, California, has been promoted to captain.

Capt. James W. Burnett, Texarkana, is now stationed at Fort Lewis, Washington.

John K. Thompson, Fort Smith, now on duty at an overseas station, has been promoted to captain.

Alfred H. Hathcock, Fayetteville, now stationed at Camp Maxey, Texas, has been promoted to major.

Lt. Vincent Mazzanti, Little Rock, is now stationed at Camp White, Oregon.

D. W. Goldstein, Fort Smith, attended the Occupational Dermatoses course conducted by the United States Public Health Service in New York during December.

The third edition of "Roentgenographic Technique" by D. A. Rhinehart, Little Rock, has been published.

Lt. Col. Henry G. Hollenberg, Little Rock, now stationed at Bushnell General Hospital, Brigham City, Utah, recently took special work at New Orleans.

S. A. Thompson, Camden, has been appointed a member of the Advisory Committee on Maternal and Child Welfare to the Children's Bureau.

Robert Watson, Little Rock, attended the recent meeting of the Association for Research in Nervous and Mental Disease held in New York City.

Recent graduates of the School of Aviation Medicine, Randolph Field, Texas, are Euclid M. Smith, Hot Springs National Park; W. A. Regnier, Crossett, and J. W. Lamb, Paragould.

Capt. W. T. Wilkins, Cotton Plant, is now stationed overseas.

M. W. Chastain, Bentonville, now stationed at Harlingen, Texas, has been promoted to captain.

Allen Cox, Helena, attended a recent Flood Control meeting in New Orleans.

F. Walter Carruthers, Little Rock, attended the recent meeting of the Southern Surgical Association in New Orleans.

Lt. Phillip T. Cullen, Little Rock, is now stationed at Oklahoma City.

Capt. Henry V. Kirby, Harrison, is now stationed overseas.

Born—to Dr. and Mrs. N. T. Hollis, Little Rock, a son, William Coker Hollis, on December 7th.

John T. Herron, Helena, has been appointed Acting Director of the Bureau of Local Health Services, Arkansas State Board of Health, and is now located in Little Rock.

Maj. William W. Johnston, Little Rock, is now in command of the 276th Station Hospital, Camp Carson, Colorado.

Capt. Louis S. Dunaway, Conway, is now stationed overseas.

Chas. T. Chamberlain, Fort Smith, attended a recent meeting of clinic managers in Minneapolis.

R. B. Robins, Camden, recently addressed the Little Rock Lions Club.

Paul C. Eschweiler, Little Rock, addressed the Kiwanis Club of that city on "Blood Plasma" recently.

Capt. J. J. Monfort, Batesville, is now stationed overseas.

"Dental Considerations of Tic Douloureux," by Robert Watson, Little Rock, appeared in the December issue of The Journal of the Arkansas State Dental Association.

Lt. Thomas P. Foltz, M. C., U. S. N. R., Fort Smith, who has been on duty in the South Pa-

cific for the past fifteen months, has been transferred to Naval Recruiting Station, Little Rock.

Dr. and Mrs. Chas. T. Chamberlain, Fort Smith, spent a Christmas vacation in Mississippi.

Lt. Col. Euclid M. Smith, Hot Springs National Park, is now in command of Station Hospital, Pampa Air Field, Pampa, Texas.

CORRESPONDENCE *

December 13, 1943

Dear Doctor:

We members of the Southeast Arkansas Medical Society and the Woman's Auxiliary assembled tonight at the Greystone Hotel, for our annual Christmas party, miss you greatly, and are mindful of the honor you bring to this Society in your service to our Country.

May God bless you and bring you safely home to us when victory is ours.

Mrs. H. T. Smith	Mrs. Tilghman E. Dixon,
Mrs. R. F. White, Sec.	Guest
Mrs. Chas. W. Dixon	Sarah Suzanne Dixon,
Mrs. J. S. Wilson	age 18 months
Annamay Leverett	Charles W. Dixon,
Mrs. J. A. Thompson	President
Mrs. M. C. Crandall	M. C. Crandall, Sec.
Mrs. Lindsey F.	S. W. Douglas,
Billingsley	Councillor
Mrs. C. C. Hanchey,	H. T. Smith
Guest	J. A. Thompson
Mrs. E. V. Leverett,	J. S. Wilson
Guest	E. Baker
Marion B. Leverett	L. F. Billingsley

* The above letter has been mailed to each member of the Southeast Arkansas Medical Society now in military service.

COMMUNIQUE

To the Editor:

Have been receiving your bulletins about the various happenings in the state and also about our fellow physicians. The Journal has been coming through regularly although a bit late.

I moved from Manhattan, Kansas, to Fort Leonard Wood, Missouri, and was there a short time, when I was transferred to Camp Carson.

Would appreciate a correction of my address. Like it here fine. The scenery is beautiful and many an afternoon I can run around in my short sleeves while there are several inches of snow on the ground. I am in command of a station hospital.

Sincerely,
William W. Johnston,
Major, M. C.

PHYSICIANS OF COUNTY DINE AT OOW PLANT

Precautions Taken by Officials Explained To Visiting Medics.

Members of the Union and Ouachita Counties Medical Societies and doctors from other surrounding communities were entertained by Lion Chemical Corporation at Ozarks Ordnance Works recently. Since it was the regular meeting time of the Union County Society, that group conducted a brief business session presided over by Dr. D. E. White, chairman.

The program included a dinner at the plant cafeteria, and tours of the plant hospital, and the manufacturing areas. Preceding the tour of the plant, A. M. Sprague, assistant works manager, explained the manufacturing processes by means of a large chart set up in the cafeteria. He pointed out the conditions that would be of particular interest to the physicians.

It was explained that the purpose of the gathering at the plant was to permit the doctors to gain first hand information knowledge of working conditions there and safety and health precautions practiced. Suggestion for such a meeting originated in the office of Chief of Ordnance.

Attending the meeting were the following physicians: Dr. A. D. Cathey, Dr. L. G. Fincher, Dr. F. L. Irby, Dr. David LeVine, Dr. Berry L. Moore, Dr. E. J. Munn, Dr. G. D. Murphy, Dr. M. V. Russell, Dr. J. B. Wharton, Dr. White, all of El Dorado; Dr. O. Atkinson, Hampton; Dr. P. H. Muse, Junction City; Dr. J. B. Jameson, Dr. W. C. Magness, Dr. Sam Thompson, Dr. B. V. Powell, Dr. J. S. Rhinehart, and Dr. Rowland Robins, all of Camden; and Dr. J. P. Clements, Stephens.

Lion Chemical officials attending were: J. M. Wadsworth, Mr. Sprague, D. H. Salyers, H. W. Van Ness, R. L. Van Zandt, Sam Umbenhauer, J. L. Slaughter and Kavanaugh W. Dodson, Jr., E. Frank Spawr attended from Lion Oil Refining Co.

Union County Medical Society has elected the following officers: President, B. L. Moore; Vice-president, E. J. Munn, and Secretary-treasurer, M. V. Russell.

The Sebastian County Medical Society has elected the following officers: President, C. W. Hall, Greenwood; Vice-president, Chas. T. Chamberlain, Fort Smith; Secretary, D. W. Goldstein,

Fort Smith, and Treasurer, W. R. Brooksher, Fort Smith.

Polk County Medical Society has elected the following officers: President, F. A. Lee, Vanderhoort; Vice-president, F. Q. McElroy, Mena; Secretary-treasurer, Edward M. Miers, Mena; Delegate, B. H. Hawkins, and Alternate, Pierre Redman, Mena.

The annual Christmas meeting of the Miller-Bowie Counties Medical Society was held December 17th with J. H. Black, Dallas, and Col. Raymond Marsh presenting the program. The Woman's Auxiliary presented a special program.
H. K. Abrams, Secretary.

ATTENTION AUXILIARY MEMBERS

Only seven subscriptions to the Bulletin have been sent in this year. For shame, Auxiliary members!

The Bulletin is the official organ of the Woman's Auxiliary to the American Medical Association. It is the only medium for furnishing state and county officers and chairmen with programs and suggestions for the year. It also contains timely and interesting material on subjects important to every doctor's wife.

County presidents, please talk "Bulletin" at your meetings and secure subscriptions and send direct to Auxiliary Headquarters, 43 East Ohio Street, Chicago, Illinois, or to me. The subscription price is \$1.00 for four issues—issued in August, December, March and May. So don't delay, subscribe today.

Let's put Arkansas "over the top" in subscriptions to the Bulletin this year.

Mrs. W. J. Hunt,
Bulletin Chairman,
306 W. Elm Street,
Warren, Arkansas

DIABETIC IDENTIFICATION TAGS

At the suggestion of the Medical Division of the U. S. Office of Civilian Defense, to prevent dangerous delay in diagnosis and to insure proper treatment during unconsciousness or coma, Eli Lilly and Company, Indianapolis 6, Indiana, in co-operation with the American Diabetes Association, will provide metallic identification tags to be worn by diabetic patients or carried in the pocket. The inscription reads "DIABETIC, If Ill Call PHYSICIAN." No advertising of any sort appears on the tags, which will be supplied to the medical profession on request.

PROPOSED CONSTITUTIONAL AMENDMENTS

The following amendments to the By-Laws of the Society were presented to the Sixty-eighth Annual Session. April 20, 1943, and are published here in accordance with constitutional provisions.

To amend Chapter V, Section I, fifth sentence, which now reads: "The committee shall report the result of its deliberations to the House of Delegates in the shape of a ticket containing the names of the three members for the office of President-Elect and of one member for each of the other offices to be filled at the Annual Session." To read: "The committee shall report the result of its deliberations to the House of Delegates in the shape of a ticket containing the names of two or more members for the office of President-Elect and of one member for each of the other offices to be filled at the Annual Session."

To amend the first sentence, Chapter VI, Section 2 of the By-Laws, which now reads: "The President-Elect shall be a member ex-officio of the Council and the House of Delegates without the power of voting." To read: "The President-Elect shall be a member of the Council and of the House of Delegates."

COMMUNIQUE

December 17, 1943

To the Editor:

I am sorry that I caused you to write the second letter for my present address. I think it mighty fine of you folks to make the effort to keep up with us so that we may have the opportunity of reading The Journal. I enjoy getting mine and read it from cover to cover, even your column, Bill.

I was in Florida for a year and just after the hot summer was about over and the weather was getting nice, they sent me up here where I could really "cool off." Anyway, I am way up here in Wisconsin, chief of medical service in one of our larger station hospitals. This is a splendid camp and we have an excellent hospital.

Regards to all the fellows.

Cordially,

Chas. H. Lutterloh,
Major, M. C.,
Headquarters, Post Med. Div.,
Hospital Branch,
Camp McCoy, Wisconsin.

RANDOM THOUGHTS OF THE SECRETARY

November 18th. With 21 adults, 2 babies and capacity cargo aboard we cruise comfortably tonight from Tulsa to Chicago again viewing the myriad lights of Fort Leonard Wood and Stateville, Illinois, prison, institutions with divergent utilizations.

November 19th. Attending the secretaries conference where many of the regulars are on hand but missing McCormack, Shoulders and Taylor. There is discussion of medical officers in the service and the need for more, of post-war plans throughout the day while tonight the editors (and all others at the conference) banquet and wash some laundry for the family.

November 20th. The secretaries again with emphasis upon the Wagner bill and the MCH plan and conclusions are not reached. So, with visiting downtown Chicago on a Saturday afternoon and the like, we are glad to board our plane Southwest bound.

November 25th. In a world which has seen nation after nation beaten into slavery, let us give thanks to God for our rare blessings.

November 26th. Omitting any discussion of his qualifications as a neuropsychiatrist, it seems obvious that Patton has not yet acquired a comforting bedside manner.

November 29th. Comes Secretary Meirs with the first 1944 membership assessments making the old state secretary glad yet wondering what has happened to Seigel and Bob Robins.

December 2nd. Purchasing a new automobile, amazed at the independence of the dealer, now enjoying his innings, but managing, at that, to secure a Coca-Cola from him over the deal.

December 3rd. Awaiting the lady of the house arriving on the Rocket at Booneville tonight, we meet Paul McConnell in the restaurant and over coffee discuss the air corps, which two McConnells ably represent, automobiles and varied subjects.

December 6th. Tonight comes Foltz, fresh from the South Pacific, reticent as always, but finally persuaded to discuss the disillusion of the South Seas from experiences on and in the islands. He brings the best story yet out of the war, that of the negro artillery unit, respectful enough in receiving orders to withhold anti-aircraft fire on Jap planes, yet temperamentally unable to carry out the orders, appreciated only when told by Foltz, whose dialect has been augmented by acquaintance with various island peoples.

December 17th. This day in Saint Louis again becoming a smoky town because of shortage of that good Arkansas coal. Greeting Goldstein in the milling Union Station crowds tonight and hearing tales of his travels to New York and Cleveland, but only a phone call to Philadelphia. Thrilled to read of Wickard's swimming from assault boat to assault boat at Arawe giving morphine—devotion above and beyond the call to duty in the glorious tradition of the medical corps.

December 20th. Pleased today to forward greetings from the Southeast Arkansas Medical Society to its members in military service. It begins to appear that repetition of our plea that letters be written our members

away from home may bring good results. If so, it's a good job.

December 22nd. Comes Paul Mahoney's used Christmas card, a striking demonstration of thrift and we only hope Calcote got one too.

December 23rd. Bob Watson visits us today en route for Christmas in Kansas and has an answer for every bit of heckling we give him.

December 24th. O, Little Star of Bethlehem, shine tonight, while we pray, that Christmas may be Christmas soon again!

COMMUNIQUE

November 26, 1943

To the Editor:

My October issue of The Journal finally caught up with me today, reminding me that I have changed addresses again, and this time, I hope, for the duration. I didn't realize how my last letter would look in print. Feel that I owe the Hempstead County Medical Society an apology for my membership card got here just after I wrote the letter. With the exception of a letter from Martindale yesterday, this is the first news I have had from the profession in the State for over two months. Cut these clippings out of some of the local papers. Thought you might be interested to know that ours probably isn't the only Society that has its problems. However, keep after Mr. Wagner, for after talking to some of the men over here and seeing their troubles, I am sure we do not want his plan at home. Incidentally, I did get several people back home to write to our representatives about the bill. Enjoyed your story about the hen, cow and cat. Hope this will be the last time that I will have to bother you with a change of address.

Sincerely,

Jim McKenzie,

Capt., M. C.

COMMUNIQUE

Nov. 19, 1943

To the Editor:

I am finally in a location where there is some work to be done and after sixteen months of loafing, I am anxious to get going.

The tropical heat is terrific during the daytime, the sun barely misses the top of the coconut trees, but at night it is very pleasant.

I am enclosing my new A. P. O. number and shall appreciate getting The Journal.

Drink a nice cold Coca-Cola and think of me.

As ever,

Ed Dunaway,

Capt. M. C.

WOMAN'S AUXILIARY NEWS

Dear Auxiliary Members:

Even though I am not able to travel this year due to the war, still, regardless of late trains, overcrowded ones, no auto or gasoline available, and other inconveniences of travel, I did manage to have the pleasure of visiting three Auxiliaries during the month of December, namely, at Malvern, DeQueen and Little Rock.

These were all splendid meetings including guests belonging to the P.-T. A.'s, social workers, teachers, nurses and many wives of doctors in the armed forces, whom we were glad to acquaint with the program we are carrying out in our Auxiliaries.

May I again thank these county auxiliaries for their kind favors shown me. I shall treasure these close contacts with you.

Nothing would give me greater pleasure than to visit each county auxiliary, but since this is impossible, I will have to have most of my contacts with you from my desk in Texarkana.

I plan to be out of the state most of January and up to the latter part of February, but after that, when you have your meetings and will write me far enough in advance, I shall try my best to come to you. I am hoping that the legislative chairmen have carried out our state legislative chairman's (Mrs. S. J. Wolferman) wishes in regard to the Wagner bill, and that our work in that direction will bear fruit.

Let me urge the committee chairmen to write articles about the work they are doing and to send these in to the Editor of The Journal of the Arkansas Medical Society or to Mrs. M. E. Foster, Fort Smith, publicity secretary, in the months designated them and to be sure that they are sent for publication in The Journal not later than the fifteenth of the month preceding publication. Anything you have done regarding your chairmanship will be of interest to our members.

May your New Year resolution be to have bigger, better and more Auxiliaries over the state.

Cordially yours,

Nettie F. Kosminsky,
President.

Through error, the name of Mrs. B. V. Powell, Camden, was omitted from the roster of the Arkansas Medical Society and Auxiliary as published in the December Journal.

On December 13, 1943, the members of the Southeast Arkansas Medical Society were guests of the Woman's Auxiliary at their annual Christmas party, in the private dining room of the

Greystone Hotel in McGehee. The assemblage was called to order by Chas. W. Dixon, who asked the blessings of God upon those present, after which Christmas songs and carols were sung in unison, with Mrs. M. C. Crandall at the piano. Turkey dinner was served on long beautifully appointed tables, decorated with silvered berries and foliage, red candles and greeneries. The Christmas tree, ablaze with lights and decorations, was placed in front of a large pier mirror at the far end of the dining room. At the conclusion of the dinner a letter to each of the fourteen members who are in Service was signed by those present, a copy of which goes to the State Journal. Games and stunts were under the direction of Mrs. H. T. Smith, chairman of the Entertainment Committee, with Mesdames White and Leverett, her assistants, in charge of the distribution of gifts from the Christmas tree. The music was in charge of Mrs. M. C. Crandall; Mrs. L. F. Billingsley sang and whistled solos, and Drs. Thompson and Leverett sang a duet. Medical jokes were told by Dr. Douglass.

Mrs. Chas. W. Dixon.

The Woman's Auxiliary to the Pulaski County Medical Society met at the Woman's City Club, Little Rock, November 23rd, with the Public Relations Committee in charge of the program.

The meeting was opened with the singing of "America." Mrs. Randolph Smith, President, introduced Dr. Paul C. Eschweiler, Professor of Medicine at the University of Arkansas School of Medicine, who explained service of the blood bank established at the hospital through the generosity of the Gus Blass Company and individual contributors. Dr. Eschweiler said the goal of the blood bank was to have as many as 1,000 units on hand at all times to meet local and state emergencies. At present there are about 300 units in reserve.

There was a great deal of interest shown in the blood bank by the various representatives of the Little Rock Federation of Women's Clubs.

Mrs. Homer Higgins,
Publicity Secretary.

RESOLUTION

WHEREAS, in the course of human events our esteemed colleague, Dr. J. A. Moore, has been removed from our Society, we, his brethren, mourn;

WHEREAS, he was one of the charter members of the former Tri-County Medical Society com-

posed of Union, Columbia and Ouachita Counties which later became the Fifth Councilor District Medical Society of which he was a past president. He was loyal in attendance rarely ever missing a meeting, and his interest and counsel had much to do with the high standard this organization has now reached,

WHEREAS, his faithful observance of the tenets of medical ethics and his readiness to answer to the call of the poor and distressed were an example to his colleagues,

NOW, BE IT RESOLVED, that the Fifth Councilor District Medical Society emulate his virtues and express to his family its heartfelt sympathy in the loss they have sustained and that a copy of this Resolution be spread upon the minutes of this meeting, a copy sent to his family, and a copy to the Journal of the Arkansas Medical Society.

Fifth Councilor District Medical Society,

J. B. Wharton,
T. H. Jones,
S. A. Thompson.

COMMUNIQUE

Dec. 8, 1943

To the Editor:

Your Random Thoughts received a couple of days ago and I was glad to get them, especially the joke about the country boy. Anything which makes you get a laugh here in * * * is worth a lot. It seems so long since I was in the States, having left there the latter part of August.

The weather here is cold. We wear long underwear together with wool clothes at all times. We "live off the land" and boil all our drinking water, in fact, we drink hot tea in preference to water, never eat any raw vegetables. This really is an isolated primitive place.

Have had the "gi trots" a couple of times and the toilet paper, made from rice, is so thin, you usually wind up by your finger going through it if

you are not real careful. But you learn to have a fine sense of touch soon.

Wishing you a Merry Christmas and Happy New Year, I am

Sincerely yours,
Hunter A. Causey,
Capt, M. C.

COMMUNIQUE

To the Editor:

Sincere apologies for not having answered your letter sooner. For your files my address is as below.

We have a fine group of men here. Waldo Regnier, of Crossett and yours truly are the only Arkansas representatives. We both recently saw Lt. Col. Euclid Smith on way to his new station some several days ago. I very much appreciate The Journal being forwarded here.

Sincerely,
Barney P. Briggs.
Capt., M. C., Station Hosp.,
Sheppard Field,
Wichita Falls, Texas

BOOK REVIEWS

Gynecology: by Lawrence R. Wharton, Ph. B., M. D., Associate in Gynecology, The Johns Hopkins Medical School; Assistant Attending Gynecologist, The Johns Hopkins Hospital; Consultant in Gynecology, The Union Memorial Hospital, Hospital for Women of Maryland, Sinai Hospital and Church Home and Infirmary. 1006 pages with 444 illustrations. Philadelphia and London: W. B. Saunders Company, 1943. Price \$10.00.

This is a well-arranged text with proper attention paid to underlying anatomic and physiologic principles and with adequate presentation of modern technics. The

**If You Can't Carry A Gun
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BUY WAR BONDS.**

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SANITARIUM**

DRUG ADDICTION

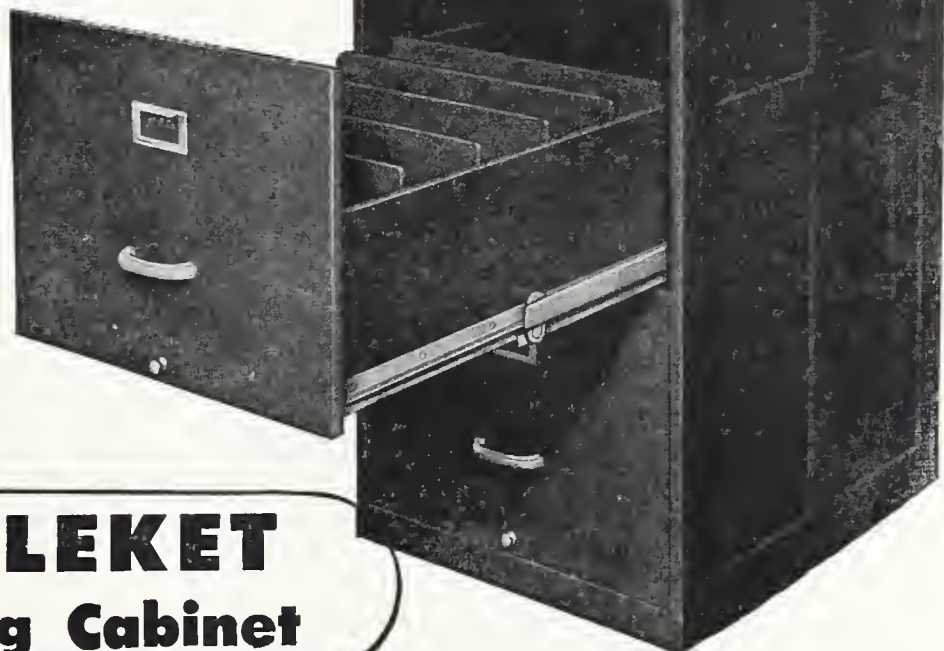
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ARKANSAS OWNED AND OPERATED

LITTLE ROCK, ARK.

inclusion of female urology appears to be an excellent thought. The discussion on pelvic infection is outstanding.

Reconstructive Surgery of the Eyelids. By Wendell L. Hughes, M. D., F. A. C. S., Hempstead, New York. Pp. 160. Illustrated. Saint Louis: C. V. Mosby Company, 1943.

This monograph covers the general principles and detailed technic of eyelid reconstruction in an excellent manner. Because of the especial application of this work, it should be of value and interest to the ophthalmologic surgeon.

Gastroenterology (in three volumes). By Henry L. Bockus, M. D., Professor of Gastroenterology, University of Pennsylvania Graduate School of Medicine. Volume I. The Esophagus and Stomach. Illustrated. 831 pp. Philadelphia: W. B. Saunders Company, 1943.

The first volume in this series deals with diseases of the esophagus and stomach and details procedures in exami-

nation of the patient. This book evidences great care in the assembly of material and reflects the experiences of a capable clinician.

Internal Medicine in General Practice: By Robert Pratt McCombs, Lieutenant, Medical Corps, United States Naval Reserve; recently instructor in Internal Medicine for the State-wide Postgraduate Program of the Tennessee State Medical Association. On leave of absence from the staffs of the Pennsylvania Hospital, the Abington Memorial Hospital and the Jefferson Medical College, Philadelphia. 694 pages with 114 illustrations. Philadelphia and London: W. B. Saunders Company, 1943. Price \$7.00.

The material in this very practical book is well selected and concisely presented for ready reference. The chapter on "Fundamentals of Diagnosis" is perhaps the most valuable and should be read and re-read. The charts accompanying the discussion on the sulfonamides are particularly helpful.

RAYMOND W. WHITTIER, B. S., M. D., F. A. C. S.

OPHTHALMOLOGY and OTOLARYNGOLOGY

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DIAGNOSIS AND TREATMENT OF HYPERTHYROIDISM

Martin M. Even, M. D.

Fort Smith

This disease, diagnosed rarely in the past, is being found more frequently in the last few years. Probably the main reason is that the medical profession is now more conscious of it and has finer methods of diagnosis and treatment.

To review the common clinical symptoms and signs again—the increase in pulse rate, increase in perspiration, increase in appetite with loss of weight and intolerance to heat must be enumerated. Along with this is the weakness which develops in severely toxic patients over a period of time. The patient shows nervous irritability by being easily angered and crying easily. Sometimes the physician may be first called when the patient is in the midst of a thyroid crisis and presents a very rapid pulse, high temperature, rapid respiration and occasionally nausea, vomiting or diarrhea.

Examination in a typical case will reveal the presence of exophthalmos which occurs in about one-half the toxic goiters. There is a widening of the lid slits due to a retraction of the upper lids (Dalrymple's sign). The stare with decreased winking (Stellwag's sign) is often impressive although Plummer states that there is increased winking. In approximately 85 per cent of cases, the upper lid lags behind the eyeball when the patient looks down. In a large percentage of patients the thyroid gland will be enlarged and occasionally a bruit may be heard over a very vascular type of gland. Occasionally the patient may complain of difficulty in swallowing or in breathing, despite the fact that the gland is not markedly enlarged. The blood pressure in a typical case usually shows an increase in systolic pressure with a slight fall in the diastolic. The tremor which is present is fine in contrast to the coarse one of Parkinson's disease.

Laboratory diagnosis depends to a great deal upon the basal metabolism and the blood cho-

lesterol level. The metabolic rate should always be determined but it must be remembered that the possibility of error is present in the mechanics of performing the examination. Along with this, the nervousness of the patient is a big factor in the actual test. These two factors sometimes will give markedly erroneous reports. The blood cholesterol should be run concurrently with the basal metabolic rate and levels of below 160 mgm. per cent are quite suggestive of hyperactivity of the gland.

A clinical test is occasionally of value in determining the diagnosis. After the patient has taken from five to fifteen m. Lugol's solution three times daily from one to two weeks, there is a marked improvement in the clinical symptoms; the nervousness is improved; the pulse has slowed, and the patient shows a gain in weight. Accompanying these symptoms the basal metabolic rate decreases and the blood cholesterol level approaches normal. This clinical test should not be done except with the idea that surgery is to be performed. Over a period of time the iodine solution loses its effect and its value would be markedly decreased in the event of a crisis or if surgery is decided upon.

Epinephrin in small doses of two to eight minims will often cause symptoms similar to a thyroid storm: the pulse will increase markedly, there will be an increase in the other symptoms and the patient will often faint. This can also be used as a clinical test.

Since hyperthyroidism is primarily a disease of middle life, its diagnosis in the extremes of life is somewhat difficult. The preadolescent child usually exhibits typical signs but diagnosis in the milder cases is a problem, especially as the basal metabolic rate is usually not obtainable. Treatment should be delayed until a definite diagnosis has been established. With the diagnosis of hyperthyroidism, surgery is advisable because of the toxic symptoms produced and because of an early appearance of the ossification centers and greater growth in the epiphysis resulting in the lengthening of the long bones beyond normal. Larger remnants of the gland should be left than in the adult.

In the aged the diagnosis of hyperthyroidism is difficult as the signs of the disease are less striking. The basal metabolic rate is elevated usually to below plus 30, but is consistent in repeated studies. The pulse is usually between 80 and 90.

Lahey¹ describes the apathetic type of elderly patient who shows apathy rather than activation. The gland is small and firm and the pulse and basal metabolic rate is as described above. These patients show a skin which is dry and cool in contrast to the usual hyperthyroid patient's, which is flushed and hot. These patients require a three weeks' preoperative preparation for a two-stage operation. The gland should be removed radically. In spite of all these precautions the operative mortality is still much higher than that of the younger patients.

Those hyperthyroid patients who are first seen with congestive failure present a difficult problem for diagnosis as the failure overshadows the hyperthyroid symptoms. The electrocardiogram does not present any definite picture but the circulation time is of value in diagnosis, being more rapid than one would expect in congestive heart failure. These present poor operative risks. With these patients, too, the less surgery done the better the chance of recovery and stage operations are advisable. Postoperatively digitalis must be continued and the patient should be given a large amount of oxygen. In spite of the fact that the patient has previously exhibited signs of congestive failure, several thousand cubic centimeters of glucose in distilled water should be given intravenously very slowly if the temperature is moderately elevated. In the presence of fibrillation which has been present preoperatively and continued postoperatively, quinidine should be withheld for four to five days in an attempt to allow the patient to restore his own regular rhythm.

The most common disorder to be differentiated from hyperthyroidism is neurasthenia. This is often quite difficult, although repeated cholesterol levels and basal metabolic rate determinations will reveal a true metabolic level. Either disease may have the weight loss, rapid pulse and palpitation, but in hyperthyroidism, the patient's appetite is usually very good, while the neurasthenic's is poor. The hyperthyroid patient is very active; the neurasthenic, comparatively inactive. In those cases which are not definitely diagnosed, surgery must be deferred. The symp-

toms in these patients are not severe enough to demand immediate surgery and over a period of weeks and sometimes months the diagnosis becomes more evident.

In severe hypertension the symptoms of tremor, nervousness, some increase of pulse and elevation of the basal metabolic rate are present. With definite clinical symptoms of hyperthyroidism, surgery is preferred as treatment. As an end-result there may not be any fall in the blood pressure. A diastolic pressure of over 100 mm. of mercury is suggestive of hypertension.

Tuberculosis will often produce an increase of temperature and pulse with loss of weight and frequently an increased basal metabolic rate, but close examination and X-ray of the chest will usually differentiate the two.

In conjunction with some of the common diseases, the treatment of hyperthyroidism presents great problems. Together with tuberculosis, hyperthyroidism tends to cause increased activity of the tuberculosis because of the patient's inability to rest or gain weight. Surgery must be resorted to after about three weeks' hospitalization with the usual preoperative treatment. Local anaesthesia with novocaine is the preferred anaesthetic.

In the presence of hyperthyroidism, jaundice is a most significant sign of probable impending crisis. Fortunately, it is rare. The jaundice is usually mild. The liver may be slightly enlarged and tender. Gall bladder and associated diseases should be eliminated.

In a very small percentage of patients with hyperthyroidism, glycosuria is found and glucose tolerance tests must be run to eliminate or confirm the presence of a concurrent diabetes. The fasting blood sugar level is raised from 130 mgm. per cent to 150 mgm. per cent, and after the ingestion of the meal from 160 to 200 mgm. per cent. These patients are older than the usual ones and should be treated with two-stage operations because of their general condition. If the diabetes is present, it will often improve postoperatively.

The diagnosis of mild hyperthyroidism is sometimes difficult during pregnancy, as the basal metabolic rate is slightly elevated after three months. Surgery may be advised through the eighth month and the patients practically all go to term. Lahey states that pregnancy is often an initiating factor in the development of hyperthyroidism, and he advises women who have had thyroidectomies not to become pregnant for at least one year.

With any type of severe infection, the inten-

¹ Surgical Practice of Lahey Clinic, Saunders & Co. Rea, Charles E.—Hyperthyroidism: Pre- and Post Problem.

sity of the hyperthyroidism is increased just as with a diabetic, and a crisis may develop. If an acute abdomen appears, surgery may be undertaken, but the patient must be treated as if he were in a thyroid crisis.

The three accepted methods of treatment for hyperthyroidism are iodine, surgery, and radiation therapy, or combinations of these three.

Iodine, as stated above, should only be given in preparation for surgery and as a clinical test.

Surgery is the most acceptable method of treatment and when following adequate preoperative preparations, gives the best result with a low mortality. This preoperative care is extremely important. The patient is to have absolute quiet and mental relaxation with bed rest, although he may be allowed up for short periods during the day to allay restlessness. The diet must be high in calories (4,000 to 5,000 daily), and should be fortified with parenteral or oral thiamine chloride. Fluids must be forced to 3,500 ccs. daily. Five to fifteen m. of Lugol's solution are given three times daily and a barbitol sedative is administered during this rest period. This preoperative treatment should be carried on for at least ten to fourteen days and with this there is usually an increase of weight, decreased pulse and nervousness with a decrease of basal metabolic rate, and increased blood cholesterol. Surgery should be deferred until these definite results are gotten with the preoperative care.

X-ray therapy is usually reserved for those cases in which any type of surgery is contraindicated and also in recurrent hyperthyroidism. It has its disadvantage in that its maximum effect takes six months and a thyroid crisis may develop during this period. It has little value in the treatment of toxic nodular hyperthyroidism. In comparable cases the end results of irradiation therapy do not equal those obtained with surgery.

Our present-day trends in thyroid surgery are toward conservatism with stage operations increasing in numbers. Ligation of the superior thyroid vessels is becoming less and less popular. The procedure itself is occasionally followed by thyroid crisis and the results of the ligation are sometimes questionable as shown by the pulse, basal metabolic rate and general physical condition of the patient.

Toxic adenomatous goiters have a much higher mortality rate than the primary hyperthyroid ones but this can be accounted for by the fact that they occur in an older age group and the number of stage operations performed

here is lower than in the primary hyperthyroid cases. Even non-toxic adenomatous goiters should be preceded by Lugol's solution, as latent cases of hyperthyroidism have flared into a crisis postoperatively.

Postoperatively the patient should be given sufficient morphine every four hours for the first several days to maintain relaxation. Approximately 3,000 ccs. of intravenous glucose are given as supportive treatment with 60 m. of Lugol's solution daily being given in the infusion.

With the onset of a postoperative thyroid crisis, the glucose should be increased to 5,000 to 6,000 ccs. per 24 hours. Five to ten grams of sodium iodide are given intravenously and the patient is placed in an oxygen tent. Several ice bags are placed about the patient for comfort. Recently spinal anaesthesia has been found to be of value in the treatment of a thyroid crisis.² The rationale of the anaesthesia is to inhibit the nerves to the adrenal medulla and thus prevent their release into the blood stream. Analgesia must be obtained to the level of the fourth dorsal vertebra. This method of spinal anaesthesia should be reserved and not used as a routine in a thyroid crisis.

To summarize briefly: In the present day treatment of hyperthyroidism, conservatism is the essential feature. Treatment with iodine should be withheld until a definite diagnosis is made. The patient should be placed on bed rest for ten to fourteen days preoperatively and given Lugol's solution. The amount of surgery to be done should be determined preoperatively with the trend toward stage operations.

²Staff Meeting Bulletin, Hospitals of the University of Minnesota. 10-23-42.

COMMUNIQUE

To the Editor:

December 28, 1943

Have been receiving the Arkansas Medical Journal regularly. The messages from old friends have recalled pleasant memories and, at times, have caused a severe case of nostalgia. I know the proper treatment for that disease but at present there is a slight technical difficulty.

My address has not changed in the past two and one-half years. Will I have to take out naturalization papers when I return? Other than the above-mentioned disease, I have no complaint for I am at a swell post and like my work.

Yours truly,

H. T. Capel, Major, M. C.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

THIS is the time of year when the commoner communicable diseases are apt to dominate the medical scene. Johnny breaks out with a rash; Mary has a suspicious parotid swelling; Jimmy's throat is red and sore; Dad has a chest cold that will bear watching for possible pneumonia. Suddenly these troubles bubble up; furiously they boil; generally they cool with equal rapidity. But there is one common communicable disease that seldom flaunts a rash, that does not start with a high fever, that fails to herald its approach by means of sore throat, overwhelming malaise, violent headache or major digestive upset. That disease is tuberculosis, and the time of the year to watch out for it is exactly twelve months long!

SEASONAL MALADIES

In combating the spread of communicable diseases, the isolation of the case throughout the period of marked infectivity is of considerable importance. At best, however, this can be only partially accomplished, for the period of infectivity so often begins hours or days before symptoms sufficiently manifest themselves to make possible a diagnosis. Mild subclinical infections go undiagnosed, yet serve to spread infection to others. Obviously, with such initial gaps in isolation procedure, we can hope to gain but little by being hyper-meticulous in carrying out the latter part of the isolation process. The effort should be two-fold: (a) to prevent, as far as practicable, the spread of infection to others; (b) to keep the time lost by the case in isolation at a minimum.

With this double objective in mind, we should avoid on the one hand, such lax regulations as would permit German measles cases to carry on their regular duties and contacts in the obvious presence of rash and swollen post-cervical lymph nodes, and on the other hand, such strict regulations as would keep scarlet fever patients routinely under isolation for six weeks or more. A well balanced communicable disease control program will endeavor to isolate suspected cases promptly and freely; will release them just as promptly when observation shows the suspicion unfounded and will extend the isolation only through the definitely and dangerously infective period.

Recommended isolation periods for the more common communicable diseases are as follows:

(Note—These are Navy suggestions. Physicians will know whether or not they conform to local health regulations.—Ed.)

Measles. Communicable from the onset of the catarrhal symptoms (usually at least three days before the appearance of the rash) until the catarrhal symptoms have ceased (usually shortly after the return of the temperature to normal and well before the rash has completely disappeared). In a case without complications or abnormal discharges, release from isolation is usually safe any time after the fifth day following the appearance of the rash, provided the catarrhal symptoms have ceased.

Mumps. Communicable from 24 hours preceding the appearance of symptoms until the subsidence of all swelling in salivary glands or involved testicles. Release from isolation is usually safe 24 hours after all swellings of salivary glands or testicles have subsided. (It should be remembered, however, that with adult males the chance of orchitis persists for about one week after the subsidence of the parotitis.)

Rubella (German Measles). Apparently communicable from 24 hours preceding the appearance of the rash until the subsidence of the rash. Release from isolation is usually safe 24 hours after the disappearance of the rash.

Scarlet fever, Streptococcic pharyngitis, Streptococcic tonsillitis. Most communicable in the first two weeks of the illness, communicable in the third week in approximately 25 per cent of cases, communicable in the fourth week in approximately 5 per cent of cases, communicable

after the fourth week in approximately 1 per cent of cases. Release from isolation is usually safe 21 days after the onset of the disease, provided there are no complications or discharges. For another three weeks after release from isolation the patient should consider his nose and throat secretions still possibly dangerous to others. Desquamation has no relation to communicability.

Chickenpox. Infectious from 24 hours preceding the appearance of the eruption until there are no longer any actual pustules. Release from isolation is usually safe when all pustules are gone (usually about seven days from onset), and the patient has taken a thorough bath and shampoo. The dry scabs apparently bear no relation to communicability.

Meningococcus meningitis. Probably communicable throughout the course of the disease and until the meningococci have disappeared from the secretions of the nose and throat. Release from isolation is usually safe when 14 days have elapsed since the onset and the fever has subsided.

Poliomyelitis. Apparently communicable the last one or two days of the incubation period, and for the first seven to ten days of the disease (virus may be found in the stools even much later in the disease). Isolation is necessary only during the first 14 days following onset.

Smallpox. This disease is apparently the most communicable of all diseases. It is communicable from the inception of the first signs or symptoms until the complete disappearance of all crusts and scabs. There is some evidence that the disease is communicable in the last one or two days of the incubation period. Isolation in screened quarters, free from vermin, is necessary until recovery is complete and all crusts and scabs have disappeared.

Diphtheria. Communicable from 24 hours before the onset of symptoms until the diphtheria bacilli have disappeared from the nose, throat or other site of infection. Isolation should be continued until symptoms and discharges have ceased and two successive nose and throat cultures, taken no less than 24 hours apart, are negative.

BuMed News Letter, Bureau of Medicine and Surgery, U. S. Navy, Captain W. W. Hall, Editor. (Journal-Lancet, October, 1943.)

Tuberculosis, too, is communicable. Tuberculosis, too, can be found preclinically, using the tuberculin test and the chest X-ray. Tuberculosis

contacts, too, must be looked for, examined and protected from further known exposure. Tuberculosis, too, responds to prompt, adequate treatment. By all means keep tuberculosis on your list!

SUGGESTED READING

So far as we have tried to urge doctors voluntarily to move into the areas where shortages are acute. This however proved an unsuccessful method in Great Britain and I am afraid we shall make the same discovery. In many cases, organized medical groups have been the stumbling block. Doctors who have gone into the services and given up practices they have built up sometimes have not wanted them taken over by other young men while they are gone.

Men who have lucrative practices do not want to move into an area which may need them badly, but which will give them inadequate income, and, frequently, an impossible housing problem for their families. County medical societies and other groups have opposed, in many cases, anything that savors of Government control, and at times even the sending of public health doctors.

These doctors are sent, as a rule, only in case of emergency or disaster. It looks to me, however, as if the health of the civilian population may force us to abandon our volunteer system and to submit to mandatory placement for the duration of the war.—Eleanor Roosevelt, "My Day," May 1, 1943.

COMMUNIQUE

December 26, 1943

To the Editor:

Thanks very much for the medical society card. Will be very happy to receive The Journal of the Arkansas Medical Society. It will be appreciated and read with interest. I am looking forward to the end of the war when I will be back in Arkansas practicing medicine.

Sincerely,

Powhatan R. Anderson,
Capt., M. C.

COMING MEDICAL MEETINGS

New Orleans Graduate Medical Assembly, New Orleans, March 6th-9th.

Regional Session, American College of Surgeons, Tulsa, Oklahoma, April 4th.

Arkansas Medical Society, Little Rock, April 17th-18th.

American Medical Association, Chicago, June 12th-16th.

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EDITORIALS

ADDRESSES WANTED

The Journal again requests the cooperation of
the membership in an effort to secure the full
military address of the following members now
in service:

A. W. Thompson, Bentonville
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John P. Eaton, Little Rock
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J. K. Sheppard, El Dorado
Byron Z. Binns, Monticello
Hollis H. Buckelew, Hot Springs

If any member knows the address of any of
the above, or if he can suggest where The Jour-
nal might obtain it, it is requested that The
Journal be notified.

REACTIONS OF SOME MEMBERS OF CON- GRESS TO THE SOCIALIZATION OF MEDICINE

Senator Kenneth McKellar, Tennessee: "I am
very much opposed to what is known as socialized
medicine." (Congressional Record, December 8,
1943, page 10574.)

Senator Chapman Revercomb, West Virginia:
In discussing a proposal to provide federal funds
for the relocation of physicians, the Senator said,
in part: "By whatever name that might be called,
whether it be called socialized medicine or State
controlled medicine or State aid to doctors, it
seems to me the provision is not a good one. . . .
Here, for the first time, the Federal Government
would be going into the business of supplying
doctors. Let the doctors move freely within their
profession. Let those who remain in our country
move freely about the country. Let the communi-
ties invite any doctor in the land to come there
and practice among those in the community. Let
the doctor go there, if he desires to do so, and if
he can meet the standards of the State to which
he moves. But do not let the Federal Government
foster the removal of doctors from one communi-
ty to another, and do not let the Federal Gov-
ernment use public funds to pay such doctors—
not for 3 months, but for any length of time—to
live there. That would be rather close to State
control. If it would not be State control, it would
be State influence in the practice of medicine."
(Congressional Record, December 8, 1943, page
10574.)

Senator Scott W. Lucas, Illinois: "If S. 1161,
when it is reported to the Senate by the Commit-
tee, contains a provision for strictly socialized
medicine no doubt a separate vote will be taken
on this proposition. In that event I shall vote
against the provision. I stated definitely in my
campaign for the Senate in 1938 that I was op-
posed to socialized medicine, and I see no rea-
son for changing my position at this time."
(Letter.)

**Congressman Joseph W. Martin, Jr., Massa-
chusetts:** In an address before the Fifteenth
Annual Scientific Assembly of the Medical So-
ciety of the District of Columbia, October 1,
1943, (inserted into the Congressional Record
by Congressman Miller of Nebraska) Congress-
man Martain said: "I do not need to remind you
that one of these groups would radically change
the status of your profession. Instead of leaving
you free, they would regiment you under a rigid
system of governmental controls. They would

curb your opportunities. They would arrest your progress. They would deprive you of your freedom. And they would do all this under the specious plea of aiding the unfortunate and giving all people security.

"These misguided individuals evidently forget that if you regiment men and women, if you eliminate the opportunity for individual progress, you kill individual initiative at the same time. * * *

"We must not shackle your great profession and restrict the service it can give to the world. If we give to some bureaucrat the power to regulate the practice and fix the fees of a physician and to govern the hospitals, we will shackle the science of medicine. We must make sure every man and every woman retains the right to select the doctors of his or her own choice. That has been a great American right and the people of this country want to keep it.

"To place the practice of medicine under bureaucratic control would not affect medicine alone; it would constitute a long forward step in putting the other professions and all American labor, industry, and agriculture permanently under the direction of a Washington bureaucracy. By whatever name we might call it, it would be a form of state socialism." (Appendix, Congressional Record, October 4, 1943.)

Congressman A. L. Miller, Nebraska: "Under the Wagner-Murray-Dingell bills the Federal Government would set up a political control of the practice of medicine. It would be a step in which not only the physician but the individual would be regimented, pigeonholed, blueprinted and made to do a physical, mental, and ritualistic goose step. The first move in a socialistic government has always been to deal with the health and the welfare of the nation. * * * The resulting regimentation would first hammer the physician and then break down his morale, his initiative, and his effectiveness. * * * Mr. Speaker, we must not foist upon the American people a system of medical practice of inferior quality and at a constantly increasing cost with a huge administrative expansion. The question is: Shall medicine continue to be practiced by men and women scientifically trained and devoted to the relief of suffering humanity and with the freedom to perfect themselves in their art or shall the practice of medicine be taken over by a group of untrained bureaucrats who will use the medical profession as a tool and the sick as clay in molding a huge political machine?" (Congressional Record, December 7, 1943, page 10489.)

Congressman Ralph E. Church, Illinois: "I am one of those who has consistently opposed Federal regimentation of the professions. You may be quite certain that this measure will receive my very special attention." (Letter.)

Congressman Stephen A. Day, Illinois: "I am definitely and positively opposed to the socialization of medicine in all its forms and the extension of bureaucratic control over one of our great professions. We have in the United States the finest medical service in the world and the health of the nation has been safe in the hands of the private practice of medicine. I shall vote to continue this system against all its enemies." (Letter.)

Congressman Chester H. Gross, Pennsylvania: "Mr. Speaker, for some time the matter of socialized medicine has been a matter of nation-wide discussion. I have always opposed it and shall continue to oppose it. * * *" (Congressional Record, December 15, 1943, page 10810.)

Congressman Charles L. Gerlach, Pennsylvania: In an address before the Lehigh County Medical Society at Allentown, Pennsylvania, November 9, 1943, (inserted into Congressional Record by himself) Congressman Gerlach said in part: "I say to you, therefore, that this latest proposal of Senator Wagner, one of the authors, is not a cure for the inequities that are admittedly a part of American private medicine. The Wagner-Murray-Dingell proposal is instead a pattern of socialized medicine for a regimented people under a totalitarian state. And that, I say, shall never be in the United States of America * * * should this measure be reported out of committee and to the floor of the House for consideration, you may be assured that I shall fight, and by voice and vote, do all within my power to defeat its insidious and un-American provisions." (Congressional Record, November 19, 1943, page A5351.)

Congressman William W. Blackney, Michigan: "The Wagner-Murray Bill is certainly a monstrosity. Yet there will be Congressmen and Senators here who will vote for it. The effort is certainly on to socialize this country. They have succeeded fairly well in some branches of finance, banking, insurance, and housing, and now are after your profession. When they get you socialized, if they should, then they will be after my profession. I certainly am not in sympathy with this socialistic trend so evident here in Washington." (Letter.)

Congressman Hubert S. Ellis, West Virginia: The Congressman inserted in the Congressional

Record an editorial from the Wayne County (West Virginia) News which he described as "very sound." This editorial after discussing the Wagner-Murray-Dingell bills concludes that a socialized medical system would be set up "that would ultimately destroy the independence of medical men, the present high standards of the medical profession. * * * It does not seem possible that free American citizens want a one-man medical system any more than they want a one-man Government." (Congressional Record, December 6, 1943, page A5686.)

Congressman Ben F. Jensen, Iowa: "Mr. Speaker, of all the un-American bureaucratic bills that have ever been cooked up by the socialistic New Dealers in and out of Washington, S. 1161, known as the Wagner-Murray bill, takes the prize. If this bill should become law, our returning veterans would certainly make good use of all the shooting experience they have had over there in order to cleanse the home front of the very thing which, supposedly, they were sent to foreign lands to stop before it reached our shores, namely, nazi-ism, fascism, or any form of communism or collectivism which would destroy our cherished Americanism." (Congressional Record, November 13, 1943, page 9583.)

Congressman John W. Gwynne, Iowa: "One of the most dangerous proposals before us is that of socialized medicine, as set forth in bills such as H. R. 2861. Under our system of free government and individual enterprise we have built up standards of medical and dental care higher than in any other country on earth. I trust the American people will think this matter over very carefully before they permit these great professions, which are so near to all of us, to be placed under political domination." (Congressional Record, October 19, 1943, page A4720.)

Congressman Walter C. Ploeser, Missouri: Congressman Ploeser inserted in the Congressional Record an editorial from the St. Louis Globe-Democrat of October 7, 1943, which he described as "a most constructive contribution, and * * * logical analysis of portions of the Wagner-Murray bill." The editorial concludes: "The medical profession should be supported in its fight to thwart the considered move to make it a slave to a socialization scheme that masquerades under false colors of humanitarianism." (Congressional Record, October 12, 1943, page A4557.)

Congressman E. C. Gathings, Arkansas: "If the sweeping provisions of this legislation are

enacted into law, the result would be to destroy the private practice of medicine. The doctor with all his training and skill would be at the mercy of one man, whose mandates and decrees would be issued from Washington, making the practice of medicine subservient to the will of the State and the politicians. * * * If this socialistic crystal-gazing scheme should be enacted into law, it would be the forerunner for the establishment of centralized Federal control of all the professions and all private business." (Congressional Record, October 4, 1943, page A4426.)

Congressman William A. Rowan, Illinois: "While no hearings have been held on the bill it is my opinion that there will be a great many amendments offered before any action is taken by the House or Senate Committees. I could not vote for any bill of that magnitude until I had made a very careful study of it and had either attended the hearings or read the complete hearings and reports. There are some features of the bill with which I do not agree." (Letter.)

Congressman Everett M. Dirksen, Illinois: "I work rather closely with Senator Byrd on a number of matters and will cooperate with him in consideration of the bill now pending to expand security benefits including federalized health service." (Letter.)

Senator Harry F. Byrd, Virginia: "I have not had an opportunity to examine this legislation in detail, as it is very far-reaching and comprehensive. I would regard as a calamity that part of the bill which socializes the medical profession. I will certainly give the fullest consideration to the matter, and I feel confident I could not vote for this legislation in its present form." (Letter.)

Senator Walter F. George, Georgia: "I cannot support it in the form in which it was introduced and I am not sure that we are ready to take any further step in extending the social security system at this time. I assure you that this matter will not be hastily approved by the Senate Finance Committee." (Letter.)

Senator C. Wayland Brooks, Illinois: "This legislation would affect practically every citizen in the country and attempts to give unprecedented powers to the Social Security Board over the lives and welfare of citizens. It would establish a unified and social insurance system, a Federal system of unemployment compensation, a Federal system of medical and hospitalization service and countless additional innovations

which would tend to socialize many other activities.

"I have always felt, and feel now, that the Medical Profession has done an outstanding job, will do a better one, and should not be brought under the arbitrary whims of bureaucracy.

"There is a strong opposition being voiced at present to such legislation. By the passage of necessary war measures many Constitutional rights of the citizen have been temporarily surrendered. To establish a system which would make these powers permanent is not appealing to many members of the Congress." (Letter.)

Senator Albert W. Hawkes, New Jersey: "I don't have to tell you what I stand for, because you know. I believe in the American system. I believe in work and more work, with some sweat. I believe in reward as an incentive to accomplishment. I believe in government regulation only to the point that is necessary to protect the proper interests of the people and never to the point where the government assumes the control of the lives of the individual, in return for an attempt to give the individual enough to eat and enough to wear and the kind of a home that governments have been known to furnish throughout the world. I believe in opposing governmental control which wrecks the hope, ambition and initiative of the private individual and I shall oppose it to the last ditch." (Letter.)

Senator Rufus C. Holman, Oregon: In a hearing held before a Subcommittee on Appropriations of the United States Senate, Seventy-eighth Congress, on H. J. Res. 159, making additional appropriations available for the maternity and pediatric program for the wives and infants of enlisted men, Senator Holman said, in part: "At the outset let me say that I am opposed to socialized medicine * * *" (Printed Hearings, Senate Committee on Appropriations, H. J. Res. 159, September 24, 1943.)

Hon. J. W. Fulbright, Arkansas: "I can say that I am not in favor of the socialization of medicine and if that feature is included in the measure as amended and in its final form for passage, I shall oppose it." (Letter.)

Hon. John L. McClellan, Arkansas: "There are enough of us in the Senate who are opposed to it to make a lot of trouble for it before it could ever be passed." (Letter.)

Hon. Oren Harris, Arkansas: "I shall use my very best efforts preventing the Government from interfering with the progress made and to

be made by the medical profession of this country." (Letter.)

Hon. Fadjo Cravens, Arkansas: "I certainly have no intention of supporting the bill in its present form. There may be some isolated good provisions in the bill, but they are certainly outnumbered by provisions which are wholly objectionable and inconsistent with American concepts." (Letter.)

Hon. Wilbur D. Mills, Arkansas: "It is the attitude of the Committee (House Ways and Means) to decrease rather than to increase bureaucratic control and its resulting regimentation." (Letter.)

In addition to the above quotations, all members of the National Congress from Arkansas have personally stated their opposition to the medical provisions of S. 1161 to various physicians and citizens in Arkansas.

COMMUNIQUE

December 24, 1943

To the Editor:

I am getting my Journal right along. Have missed very few. Have enjoyed them for their news especially.

In an effort to keep the address problem straight I want to give you my new address, and if possible to cancel the one to which all of my Journals have been sent. Incidentally, it never was my address and how the Journals kept reaching me is beyond me. I made at least two attempts to give you the correct address but apparently the letters never reached you. It was a marvel at times to trace the wanderings of my Journals by the scribble of various mail clerks forwarding it. Some have gotten completely out of the Navy into the Army and back to me, well read usually, too.

On my return to the states three months ago, I spent some time in the Navy School of Aviation Medicine at Pensacola. From there I was sent to Naval Air Station, Vero Beach, Florida. Consider that my address until further notice.

Saw a good deal of Raymond Cook while in Pensacola. He is about the only pre-war acquaintance I have run across in twenty months in the Navy.

Thanks again for sending the Journal in spite of all the burden it must be to keep up with us.

Merry Christmas!

Max Baldrige,
Lt., M. C., U. S. N. R.,
Naval Air Station,
Vero Beach, Florida

PROCEEDINGS OF THE SOCIETIES

The Fifth Councilor District Medical Society met in dinner session at El Dorado January 11th for the following program: "Some Modern Concepts of the Treatment of Burns," Neal Owens, and "Organic Diarrhea," Donovan C. Browne, both speakers of New Orleans. Officers elected are: President, G. F. McLeod, Magnolia; Vice-president, A. D. Cathey, El Dorado, and Secretary, W. C. Magness, Camden.

Searcy County Medical Society has elected the following officers: President, E. G. Fendley, Leslie; Vice-president, W. T. Moore, Marshall; Secretary-treasurer, J. O. Leslie; Delegate, J. O. Leslie, and Alternate, E. G. Fendley.

Crawford County Medical Society has elected the following officers: President, F. A. Boomer, Van Buren; Vice-president, C. J. Campbell, Mulberry, and Secretary-treasurer, S. C. Grant, Mulberry.

Hot Spring County Medical Society has elected the following officers: President, R. V. McCray; Vice-president, W. F. Barrier; Secretary-treasurer, M. D. Prickett; Delegate, H. L. Brown, and Alternate, W. G. Hodges.

Hempstead County Medical Society has elected the following officers: President, Don Smith, Hope; Vice-president, J. E. Gentry, McCaskill; Secretary-treasurer, H. G. Heller, Hope; Delegate, Capt. J. G. Martindale, and Alternate, J. E. Gentry.

Johnson County Medical Society has elected the following officers: President, Earle H. Hunt; Vice-president, Geo. L. Hardgrave; Secretary-treasurer, G. R. Siegel; Delegate, Earle H. Hunt, and Alternate, G. R. Siegel.

Saint Francis County Medical Society has elected the following officers: President, D. A. Mohler, Palestine; Vice-president, J. M. Roy, Forrest City; Secretary-treasurer, J. O. Rush, Forrest City; Delegate, A. B. Caldwell, Forrest City, and Alternate, D. A. Mohler.

Bradley County Medical Society has elected the following officers: President, W. N. Roark, Hermitage; Vice-president, Rufus Martin, Warren; Secretary-treasurer, W. J. Hunt, Warren;

Delegate, W. B. Reasons, Hermitage, and Alternate, W. J. Hunt.

Chicot County Medical Society has elected the following officers: President, B. C. Clark; Vice-president, W. A. Craig; Secretary-treasurer, M. K. Bottoroff; Delegate, J. H. Burge, and Alternate, B. C. Clark.

Cross County Medical Society has elected the following officers: President, A. F. Barr, Cherry Valley; Vice-president, J. S. Miller, Wynne; Secretary-treasurer, Thos. Wilson, Wynne; Delegate, Ruffin Longest, Wynne, and Alternate, A. F. Barr.

Garland County Medical Society has elected the following officers: President, F. S. Tarleton; Vice-president, L. E. Reed; Secretary-treasurer, W. E. Gray; Delegates, John M. Proctor, J. S. Stall and C. E. Garratt; and Alternates, G. C. Coffey, Foster Jarrell and D. C. Lee.

Capt. Wilfred R. Parsons, Little Rock; has been transferred to the 35th General Hospital, Fort Sill, Oklahoma.

John H. Calley, Little Rock, now stationed at Seventh Service Command, Omaha, has been promoted to lieutenant colonel.

Brooks R. Teeter, Russellville, now stationed at Camp Hood, has been promoted to captain.

Robert L. Bryant, Arkadelphia, has been called to active duty as Captain, Medical Corps, Army of the United States, and assigned to Jeanerette P. W. Camp, New Iberia, Louisiana.

COMMUNIQUE

Dec. 23, 1943

To the Editor:

I just received the September issue of The Journal. It most likely came by boat, and * * * is a long way from home. Anyway, I got it for Christmas, and it reminds me of a lot of friends both at home and overseas.

My job over here, in addition to being a group flight surgeon, is ear, nose and throat consultant for the * * * wing of the A. T. C. I am seeing a lot but get to do very little surgery.

My majority came through in November.

Best regards to all.

John W. Smith, Major, M. C.

PERSONALS AND NEWS ITEMS

Maj. Albert De Groat has been transferred from Camp Rucker, Alabama, to Kennedy General Hospital, Memphis.

Ralph E. Crigler has been re-elected president of the Fort Smith Boys' Club.

Geo. B. Fletcher, Hot Springs National Park, has been reappointed to the Board of Trustees of the State Hospital.

C. J. Raney has moved from Hot Springs National Park to Yazoo City, Mississippi.

Gilbert O. Dean and Paul W. Hoover, Little Rock, have been elected to fellowship in the American College of Surgeons.

J. H. Fowler, Harrison, has retired from practice and sold his office to W. A. Bradley, Jasper.

Lt. Max Baldridge, Conway, is now on duty at Naval Air Station, Vero Beach, Florida.

Capt. Lyle L. Hassell, Conway, is now stationed at the Armed Forces Induction Station, Fort Sam Houston, Texas.

H. T. Capel, Pine Bluff, now stationed overseas, has been promoted to major.

"Empyema: Prophylaxis and Treatment," by A. B. Dickey, State Sanatorium, appeared in The American Review of Tuberculosis for October, 1943.

Alan G. Cazort, Little Rock, addressed the Sixth Annual Forum on Allergy in Saint Louis January 22nd on "Critical Evaluation of Drugs Used in Treatment of Asthma."

Capt. Marvin B. Crow, Warren, is now on duty at the Station Hospital, Fort Crockett, Texas.

C. S. Early has been elected a director of the Merchants and Planters Bank at Camden.

F. J. Scully has been elected vice-president of the Hot Springs Chapter, National Sojourners.

L. B. Jones, Benton, has been transferred to Helena as health director.

RANDOM THOUGHTS OF THE SECRETARY

December 29th. Comes visiting Byron Bennett, thirty pounds heavier from an "Aussie" beef diet and the talk ranges from the Wagner bill to individual physicians who are far and away, but mostly we tell him the story of procurement and assignment, he being the first doctor with whom we have talked who never heard of it.

January 11th. Under the guidance of Eberle the wives talk on the faults and the rare virtues of the husbands at tonight's gathering of the Sebastian County Medical Society, the wives and Eberle greatly enjoying the occasion. Elizabeth Wolferman tells the tale of the rooster who had an operation; Florence Blair says that Arless is "doing the best he knows how"; Dorothy Adams says "we've been having babies"; Earle Hunt's wife says it would not do to say anything nice about Earle at this late day with his heart out of order; Ella Eberle says "Walter has quit griping"; and Juliette Moulton gives stirring thought in original beautiful words to husbands at home and sons at the front.

January 20th. With the Moultons, the Wolfermans, and our relations visiting Half-Circle E ranch of the Eberle's way over in Crawford County where there is much of conviviality, an abundance of good food with an Eberle-raised ham and where we busy ourselves throughout the evening passing the apple sauce to the hostess and in efforts to promote dissension between the Eberle canine and the Moulton canine.

January 21st. Comes Paul Lanier eager to give the old procurement and assignment chairman another headache by departing a critical area for service with the armed forces.

PROPOSED CONSTITUTIONAL AMENDMENTS

The following amendments to the By-Laws of the Society were presented to the Sixty-eighth Annual Session, April 20, 1943, and are published here in accordance with constitutional provisions.

To amend Chapter V, Section I, fifth sentence, which now reads: "The committee shall report the result of its deliberations to the House of Delegates in the shape of a ticket containing the names of the three members for the office of President-Elect and of one member for each of the other offices to be filled at the Annual Session." To read: "The committee shall report the result of its deliberations to the House of Delegates in the shape of a ticket containing the names of two or more members for the office of President-Elect and of one member for each of the other offices to be filled at the Annual Session."

To amend the first sentence, Chapter VI, Section 2 of the By-Laws, which now reads: "The President-Elect shall be a member ex-officio of the Council and the House of Delegates without the power of voting." To read: "The President-Elect shall be a member of the Council and of the House of Delegates."

THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

The eighth annual meeting of The New Orleans Graduate Medical Assembly will be held this year March 6-9. This organization has grown by leaps and bounds. More than four hundred out-of-state visitors attended last year's session than had ever attended before. Many of these men were in the armed services and came from all over the United States. Twenty-seven different states as well as the District of Columbia were represented. There was a slight diminution in the number of local members who attended due to the fact that many of them are in the Army or Navy.

The program this year is fully equal to that of last year and of previous years. A large number of guest speakers of distinction and renown have accepted the invitations to appear on the program of this meeting. They include such men as Dr. Chevalier L. Johnson, the father of bronchoscopy; Dr. Robert L. Levy, professor of Clinical Medicine at Columbia; Dr. Walter L. Palmer, professor of Medicine, University of Chicago; Dr. Ralph H. Major, professor of Medicine at the University of Kansas School of Medicine; Dr. Paul R. Cannon, head of the Department of Pathology at the University of Chicago, and Dr. Abraham Myerson, clinical professor of Psychiatry at Harvard Medical School. In the field of surgery are to be found such speakers as Commander L. Kraeer Ferguson, assistant professor of Surgery at the University of Pennsylvania; Dr. George T. Pack, assistant professor of Clinical Surgery at Cornell University. In proctology Dr. Louis A. Buie, chief of Department of Proctology at the Mayo Clinic, will discuss the problems in this particular field. In orthopedic surgery, Dr. H. Winnett Orr, well known for his method of treatment of bone fractures, will give several papers. In obstetrics, Dr. John W. Harris, professor of Obstetrics and Gynecology at the University of Wisconsin Medical School, and Dr. Robert A. Ross, associate professor of Obstetrics at Duke University, will have papers on

the gynecologic and obstetrical conditions. Dr. Carroll S. Wright, professor of Dermatology and Syphilology at Temple University School of Medicine, will represent the specialty of dermatology, and Dr. Frank Hinman, clinical professor of Urology at the University of California Medical School, will give instructive talks in their particular field of medicine. Altogether the list of speakers is outstanding, and to hear them will well repay those who register and attend the meeting.

The members of The New Orleans Graduate Medical Assembly will welcome visitors and speakers at this annual convocation. It is to be hoped that the attendance will equal that of last year. It is particularly desired that the members of Army and Navy installations in Louisiana and Mississippi, or in fact any nearby state will feel welcome to attend the meeting.

COMMUNIQUE

To the Editor:

There is no doubt in my mind but that you will be surprised when you get this note from me, but surprised or not, I want to thank you for the Journals regularly received and I enjoy all the news contained therein.

I am no longer at Fort Bliss, Texas. At present I am a member of the examining board at the Armed Forces Induction Station, Fort Sam Houston, Texas. You may send The Journal to the following address:

822 Holliday Street,
San Antonio, Texas.

I sincerely hope the doctors back home continue their fight against state medicine. When the war is over, I, like many others, will hope to return home to a practice that is not contaminated by the politicians; to have all prescriptions passed by a board of censors and made out in six copies, would be one hell of a note for a doctor in a free country.

So long, and good luck.

Lyle L. Hassell, Capt., M. C.

MT. MERCY SANITARIUM

DRUG ADDICTION

As one of its services, Mount Mercy Sanitarium offers facilities for treatment of patients addicted to habit forming drugs. The method is relatively short, requiring seven days. Technic is such that patient is practically free from symptoms of withdrawal during treatment. No Hyoscine used.

MOUNT MERCY SANITARIUM

A. L. CORNET, M. D., Department Director

LINCOLN HIGHWAY—29 MILES FROM CHICAGO LOOP

DYER, INDIANA

WOMAN'S AUXILIARY NEWS

Sebastian County Medical Society Auxiliary met January 10th for luncheon and a business meeting at which the president, Mrs. W. F. Rose, presided. Mrs. J. L. Kellum and Mrs. Walter Eberle were hostesses. Mrs. Kellum, Hygeia chairman, reported that nine new subscriptions to the publication had been received since last meeting.

No program was arranged and members who could do so went in a group to the Red Cross surgical dressing rooms to work.

Other members present were Mrs. J. S. Southard, Mrs. Davis W. Goldstein, Mrs. Sidney J. Wolferman, Mrs. Arthur Hoge, Mrs. Everett Moulton, Mrs. B. L. Ware, Mrs. S. P. Stubbs, Mrs. W. R. Brooksher, Mrs. C. W. Hall of Greenwood and the president, Mrs. Rose.

The Auxiliary to the Sevier County Medical Society honored the state president, Mrs. L. J. Kosminsky of Texarkana, at luncheon at the Haynes Hotel Tuesday. Mrs. Pierre Redman of Mena, president, presided.

The dining room was attractively decorated in keeping with the Christmas season. The central decoration of the U-shaped table was a snow scene with Santa and his reindeer.

Following the invocation by Miss Pearl Williamson, Mrs. Clarence Hooper, accompanied by Mrs. L. O. Shull, of Horatio, sang two solos.

Other numbers on the program included a discussion on the Wagoner Bill by Mrs. William Hibbits, a member of the national board; "The History of the Auxiliary," Mrs. P. H. Phillips of Ashdown, district chairman; Mrs. Kosminsky discussed the program of the state and national auxiliaries and stressed two new committees, (1) the Doctors' Aid Corps and (2) The War Work Committee; Mrs. Minor Milwee, president of Central School P.-T. A. opened the discussion on Hygeia magazine and reports were heard from various schools in regard to the use of the magazine.

Covers were laid for Mrs. Kosminsky, Mrs. Hibbits, Mrs. Redman, Mrs. James, Mena; Mrs. Leonard Hampson, Lockesburg; Mrs. Dickinson, Mrs. Shull, Mrs. Hooper, and Mrs. Nellie Hill, Horatio; Mrs. Phillips, Ashdown; Miss Pearl Williamson, Mrs. Schley Manning, Mrs. Milwee, Mrs. Dode Smith, Mrs. Ola Meariman, Mrs. R. Elbert Leslie, Mrs. R. L. Hopkins, Mrs. C. A. Archer, Mrs. O. B. Tate, Mrs. J. S. Hendrix, Mrs. C. C. Thompson, and Mrs. C. E. Kitchens, DeQueen.

WHAT EVERY WOMAN DOESN'T KNOW— HOW TO GIVE COD LIVER OIL

Some authorities recommend that cod liver oil be given in the morning and at bedtime when the stomach is empty, while others prefer to give it after meals in order not to retard gastric secretion. If the mother will place the very young baby on her lap and hold the child's mouth open by gently pressing the cheeks together between her thumb and fingers while she administers the oil, all of it will be taken. The infant soon becomes accustomed to taking the oil without having its mouth held open. It is most important that the mother administer the oil in a matter-of-fact manner, without apology or expression of sympathy.

If given cold, cod liver oil has little taste, for the cold tends to paralyze momentarily the gustatory nerves. As any "taste" is largely a metallic one from the silver or silverplated spoon (particularly if the plating is worn), a glass spoon has an advantage.

On account of its higher potency in Vitamins A and D, Mead's Cod Liver Oil Fortified With Percomorph Liver Oil may be given in about one-fourth the dosage of ordinary cod liver oil, and is particularly desirable in cases of fat intolerance.

COMMUNIQUE

December 16, 1943

To the Editor:

Up until a few months ago I was receiving The Journal regularly and enjoying it very much. I like to keep in touch with the physicians of the state and events of interest to us all. I will appreciate your adding my name to the mailing list again.

As a group I am sure that the medical profession has and is supporting the war effort as completely as any group in the nation. Your skill, long hours and untiring efforts to maintain a high standard of health for the nation is one of the big factors in keeping up the high production rate of essential war materials. The medical profession is doing its task well, both at home and in the service.

Capt. C. L. Hyatt and I have completed twenty months in the * * * and I can assure you that we are really looking forward to seeing the States again.

My sincere best wishes to each and every member of the Arkansas Medical Society for a very Merry Christmas and a Happy New Year.

Sincerely yours,

R. F. Hyatt, Capt., M. C.

COMMUNIQUE

Dec. 29, 1943

To the Editor:

Your long and very interesting letter of Dec. 14 arrived several days ago and I appreciated hearing from you very much. Mail call is one of the "highlights" in the life of all soldiers and especially so when outside the good old U.S.A. Knowing how busy you are, I realize that writing to all of the physicians on foreign duty was quite an undertaking but I can assure you that the letters will be greatly appreciated.

Until a short while Howell Brewer was stationed here and he has done a splendid job. You will probably see him in the near future, if you haven't already, and he should be able to recount some very interesting experiences.

I realize that there is a determined effort by some to put State Medicine across and I know that every effort is being made to enlighten the public and our leaders in congress of the dangers of State Controlled Medicine. I am not in a position to observe or study any plan of State Medicine in operation but in many areas there are medical officers who will be informed on the subject and will be able to bring back some valuable information.

Congratulations to Dr. Wootton of Hot Springs as the new President of the Southern Medical Association. That is quite an honor and a distinction not only to Dr. Wootton but also to the Arkansas Medical Society for the good work you all are doing.

At the present time we are enjoying (?) a severe snow storm, usually referred to as a "Williwa." To one who grew up in the south, where snow and high winds are rare, the combination of snow and a fierce wind presents quite an interesting sight. It is difficult to walk against the wind and almost as difficult to keep from running when walking with the wind.

Had a letter from Capt. C. L. Hyatt a few days ago. Capt. G. M. Hogaboom of Hot Springs is with him and they are all getting along fine.

Thanks again for the interesting letter. Best of luck and best wishes for a Happy New Year to each and every member of the Arkansas Medical Society.

Sincerely yours,

R. F. Hyatt, Capt., M. C.

COMMUNIQUE

January 14, 1944

To the Editor:

After 17 months at my first post, I have been transferred to the 35th General Hospital, Fort Sill, Oklahoma.

The Journal has been reaching me ever since I have been in service and I certainly have enjoyed reading every issue.

I have been receiving the special bulletins sent out to the men in the armed forces, and, believe me, they are doing more to keep us in touch with things than any other letter, bulletin, card or publication. Keep them coming.

Here at Fort Sill, I have not seen any other medical officers from Arkansas, but in my own unit are a number of them who had previously been stationed at Camp Robinson. Many of our enlisted men had their basic training there too.

According to the reports from the battlefronts, Arkansas doctors are upholding the fine traditions of the profession.

I like the service and the work I am doing but, believe me, the streets of Little Rock would be a beautiful sight right now.

Cordially,

Wilfred R. Parsons,
Capt., M. C.,
35th General Hospital
Fort Sill, Oklahoma

BOOK REVIEWS

Atlas of Obstetric Technic. By Paul Titus, M.D., Obstetrician and Gynecologist to the Saint Margaret Memorial Hospital, Pittsburgh. Pp. 180. Illustrated. Price \$7.00. Saint Louis: C. V. Mosby Company, 1943.

The author has shown in pictured detail procedures and operative practices which will supplement the more exhaustive texts. The busy practitioner will be enabled to refresh his knowledge of obstetric procedures by the helpful suggestions and well-selected illustrations.

Collected Papers of The Mayo Clinic and The Mayo Foundation. Edited by Richard M. Hewitt, B.A., M.A., M.D.; A. B. Nevling, M.D.; John R. Miner, B.A., Sc.D.; James R. Eckman, A.B.; and M. Katherine Smith, B.A. Volume XXXIV, 1942. 999 pages with 176 illustrations. Philadelphia and London: W. B. Saunders Company, 1943. Price \$11.00.

This volume continues the high standards set by former editions. Among the recent advances discussed are the newer chemotherapeutic agents, penicillin and gramicidin. The book contains much of interest to all physicians, giving practical information of much value to the specialist and the practitioner alike.



One cold after another

Adrenal cortical insufficiency notoriously lowers resistance and increases susceptibility to infections. The patient with asthenia and weakness, low resistance and low muscle tone, due to cortical insufficiency, may also complain that common respiratory infections persist and recur.

Prompt treatment of the cortical insufficiency with **Adrenal Cortex Extract (Upjohn)** may speed recovery and lower the frequency of recurrence of infections.

The whole cortical hormone is a complex of more than twenty active principles. These are unduplicated to date by any synthetic substance. A *natural* complex such as Adrenal Cortex Extract (Upjohn) remains the most effective treatment for cortical insufficiency.

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Sterile solution in 10 cc. rubber-capped vials for subcutaneous, intramuscular and intravenous therapy



ANOTHER WAY TO SAVE LIVES . . . BUY WAR BONDS FOR VICTORY

THE COUNCIL URGES SUPPORT OF JOURNAL ADVERTISERS

SHOULD VITAMIN D BE GIVEN ONLY TO INFANTS?

Vitamin D has been so successful in preventing rickets during infancy that there has been little emphasis on continuing its use after the second year.

But now a careful histologic study has been made which reveals a startling high incidence of rickets in children 2 to 14 years old. Follis, Jackson, Eliot, and Park* report that postmortem examination of 230 children of this age group showed the total prevalence of rickets to be 46.5%.

Rachitic changes were present as late as the among children dying from acute disease than in those dying of chronic disease.

The authors conclude, "We doubt if slight degrees of rickets, such as we found in many of

our children, interfere with health and development, but our studies as a whole afford reason to prolong administration of vitamin D to the age limit of our study, the fourteenth year, and especially indicate the necessity to suspect and to take the necessary measures to guard against rickets in sick children."

* R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, *Am. J. Dis. Child.* 66:11, July, 1943. fourteen year, and the incidence was higher

**If You Can't Carry A Gun
Shoulder The Cost Of One
BUY WAR BONDS.**

RAYMOND W. WHITTIER, B. S., M. D., F. A. C. S.

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The JOURNAL

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No. 10

PERFORATED PEPTIC ULCER AND COMPLICATIONS *

(Report of Four Cases)

MILTON BERRY BOWMAN, M. D.
Hot Springs National Park

This paper was inspired by a recent case of perforated peptic ulcer in which the writer, to his discomfort, encountered all of the complications it seemed possible to meet. In looking back over three other ulcer perforations, the subject seemed interesting enough to review in some detail.

That perforation of peptic ulcer is not rare is, of course, well known but the variety of complications possible in these cases, postoperatively, are so numerous that the treatment of them runs the gamut from physiological chemistry to surgery.

No attempt to trace the history of peptic ulcer nor any of the complications of postoperative surgical cases shall be attempted nor shall the writer attempt to trace any of the current procedures back to Hippocrates!

Peptic ulcers occur in the stomach and duodenum. They also occur in Meckel's diverticulum but the latter are of small incidence compared to the former two and they will not be included in this paper. Ulcers on the gastric side of the pylorus are most commonly found in a limited area about the lesser curvature whereas those in the duodenum are scattered—though most frequently occur anteriorly. Ochsner believes that victims of this lesion have an ulcer predisposition and tissue susceptibility. Many ulcers are discovered only when the patient suffers sudden hematemesis or at times—actual perforation. I have recently seen two patients demonstrating each of these complications.

Carr and Foote state that it is generally agreed that two factors necessary in the production of peptic ulcer and their maintenance, e. g., injury and devitalization of the gastric or duodenal

epithelium followed by digestion by gastric ferments and continued irritation by the hyperacidity that the majority of these patients suffer. Many theories have been advanced to explain peptic ulcer from heat, circulatory dysfunctions, mechanical factors, nerve mechanisms, etc., etc. Ochsner, Gage and Hosei¹ were able to demonstrate a very definite relationship between peptic ulcer and gastric chemism and Carr and Foote² were able to produce ulcers in the stomach and duodenum of dogs by ligation of the common bile duct, thereby depriving the animals of the neutralizing effect of bile on the gastric acid. They concluded that these ulcers were produced by physiological digestion of spontaneous hemorrhages in the mucosa. Such digestion, leaving a break in the continuity of the mucosa of the stomach or duodenum, thus exposed it to direct action of acid.

The complications of progressive ulcer of the stomach or duodenum are primarily two—(a) hemorrhage and (b) perforation. It is with the latter that this paper is concerned.

Perforation may be acute or subacute. One of the cases reported here was undoubtedly a subacute perforation. In this type of perforation, there has usually been inflammatory reaction preceding the actual perforation with a resulting walling off of the site at which the actual rupture occurs. Thus, spillage is into a localized area and general peritonitis with its concomitant complications is not likely. Horsley³ states that peptic ulcer is sometimes discovered at autopsy where there were no clinical symptoms elicited in the antemortem history. Furthermore, it is not unlikely that there may be some subacute perforations in which the patient survives and attributes his discomfort to simply "indigestion." An accurate incidence of subacute perforation would thus seem difficult to determine.

Acute perforation is that in which sudden rupture of the ulcer crater, through the gastric or duodenal wall, occurs. There may or may not have been preliminary ulcer history—usually there is. Abell⁴ states that approximately 80 percent of the acute perforations occurring in the duodenum do so on the anterior wall and that 90

* Captain, M. C., A. U. S., Chief of Surgical Service, Station Hospital, Turner Field, Georgia.

percent of those on the stomach side of the pylorus perforate anteriorly. If the lesion must perforate, it is at least to the surgeon's advantage to have this lesion at a point of easy access.

The diagnosis of perforated peptic ulcer is not exceedingly difficult. The story is usually that of a patient with past history of "indigestion" who suddenly suffers severe abdominal pain of excruciating intensity with or without vomiting. When seen, these patients are usually ashen in color, forehead covered with beads of cold perspiration, apprehensive expression, shallow breathing, in an effort not to move the abdominal muscles which, when palpated, are boardlike in defense. Pain is usually referred to the epigastrium but is very frequently near the umbilicus, to the left or below the umbilicus, localized in those areas or radiating upward and to the right. Tenderness usually corresponds to the areas of pain. Palpation is difficult due to rigid abdomen. Morphia in the usual one-quarter grain dose may afford little or no relief. In one of the cases cited, one-half grain morphia gave no relief and in another, three-quarter grain was required to ease the patient. A patient exhibiting this syndrome should certainly be classified as an acute abdominal emergency (chest pathology being ruled out) whether there is an ulcer history or not.

At times a differential diagnosis is not easy and while indiscriminate surgery is always to be deplored, certainly here is one situation in which it is better to operate than to temporize. If the abdomen is opened and no ruptured ulcer is found, further exploration likely will disclose another surgical entity. Even if no surgical condition is discovered, little harm has been done to the patient, whereas, if an ulcer perforation were present and the patient were not operated on, his chance of survival has been taken from him. Furthermore procrastination in this condition is to be condemned—it is an unnecessary and criminal risk to the patient to wait to see how he is in one hour, or two hours or next morning. The mortality rate after six hours is appalling and rises rapidly for each hour thereafter.

Blood counts taken within an hour or so of perforation of a peptic ulcer are seldom illuminating. The white cells have not had time to respond sufficiently to elevate the count nor give a helpful differential count, and to wait until this does occur is folly. Probably the one laboratory measure that offers most, with least damage to the patient, is x-ray. Roentgenograms should be made to determine the presence of free air in the peritoneal cavity. It is the usual practice to

make these plates with the patient in the upright position in an attempt to demonstrate air collected beneath the diaphragm. About 20 to 25 percent of actual acute perforations will fail to demonstrate pneumo-peritoneum in this manner. Williams and Hartzell⁵ advocate a technique with obvious advantages, i. e., roentgenograms made with the patient in the left lateral position. They were able to increase the percentage of positive films from 76.2 percent, in the upright position only, to 89.7 percent of positive films where the left lateral position was used. An increase of 13.5 percent positive results is certainly worthy of emulation. These workers also bring out an important anatomical consideration in that the shape of the stomach is such that, with the patient on his left side, the pyloro-duodenal end of the stomach is elevated and the fluid content, therefore, gravitates toward the fundus and cardiac region with decreased spillage while the air pushes upward toward the ulcer, allowing a greater amount of air into the peritoneal cavity to show on the x-ray. They bring out the fact that with the upright position, the gastric content gravitates toward the pylorus and the perforation with additional spillage into the peritoneal cavity and preventing the escape of the relatively harmless air.

Once a perforation of a peptic ulcer has been suspected or proven, surgical intervention is imperative. It is easy to determine **when** to operate because the answer is "immediately" (unless, of course, the patient is in profound shock). Early there is little shock, but if the latter is present, it can usually be combatted by intravenous saline, gum acacia or, best of all, blood or blood plasma, if the latter can be gotten at once. The shock therapy can be carried out while the patient is on the operating table. It is generally accepted that the operative procedure shall be the simplest procedure possible, i. e., simple closure and nothing else. Closing is usually easily effected by suturing the ulcer margins together and then inverting the area, finally suturing a piece of omentum over the site. If the ulcer margins are so friable as not to lend themselves to suture, then simply tacking omentum over the perforation must suffice. Procedures, such as gastric resections and gastro-enterostomies, are not to be considered except in most unusual conditions such as complete obstruction or in perforation of a gastric carcinoma. The abdomen is, in the general consensus of opinion, best closed without drainage as the latter is hardly necessary and is an added risk to later wound separation. Hartzell and Sorock⁶ advocate simple closure

through a transverse incision as the technique of choice. The transverse incision naturally lessens the hazard of postoperative wound separation with evisceration.

Immediately after the patient's return from the operating room, the campaign becomes one of preventing the complications that are so liable to occur. Peritonitis, ileus, subphrenic abscess, localized abscesses about the peritoneal cavity, atelectasis and hypostatic pneumonia are now the bugbears to be avoided.

That some degree of peritonitis will occur, is obviously inevitable. The degree and type, however, may mean the difference between a fatal or a nonfatal outcome. After six hours, usually a bacterial peritonitis is to be contended with, hence the necessity of early operation.

Davison, Aries, and Pilot⁷ state that the offending organism, in the order of their importance and frequency are: (1) bacillus coli and hemolytic bacillus coli, (2) streptococcus hemolyticus (alpha and beta), (3) staphylococci and (4) anaerobes. That the bacteriology directly affects the prognosis was illustrated in their cases in that all cases, having both streptococci and bacillus coli, died. Sixteen cases with positive cultures resulted in twelve deaths or 75 percent mortality for the positive cultures; of thirty-four cases with sterile cultures, only four died—a mortality rate of 8 percent. It is believed that the increase in positive cultures, after the first six hours, is due to invasion of the upper bowel by organisms normally found in the lower bowel. Davison, et al., consider this due to early chemical peritonitis with a cessation of peristalsis and a cessation of secretion of hydrochloric acid, thus creating a situation suitable for proximal migration of bacteria from the lower bowel. No matter what mechanism permits the development of a pathogenic bacterial flora in the peritoneal fluid, the important fact is that a positive bacterial culture forecasts a gloomy outcome.

Ochsner⁸ has very plainly described metaparotomyl ileus and the measures to be used in prophylaxis thereof. Here we may frequently have to contend with a dynamic ileus such as in case four to be discussed. Morphine, grain one-quarter, given routinely every four hours for the first eighteen to twenty-four hours, undoubtedly increases intestinal tone and may prevent metaparotomyl ileus. Furthermore, in an adynamic ileus, its use is certainly to be considered. The writer had the opportunity to observe the effect of various drugs on intestinal motility. Experiments conducted by placing balloons in the intestine of dogs and intestinal fistulae in human

patients, and then making kymographic tracings after the hypodermic administration of morphine, pitressin, pituitrin, etc., demonstrated to the writer's mind that the morphine was most reliable of all in early onset of increasing the gut tone and in duration of maintaining such tone. This, of course, was shown much earlier in more extensive experiments by Ochsner and Gage⁹ who concluded that morphine most certainly should be used in cases of adynamic ileus. They further demonstrated the value of hypertonic Hartman's solution as an adjunct in overcoming paralytic ileus. Probably much of the value of Hartman's solution lies in its ability to add potassium calcium and sodium to the blood stream. Falconer, Osterberg and Bergen¹⁰ have shown that there is a rather marked loss of potassium, calcium and sodium in obstructive cases in the loss of stomach secretions through vomiting or continued suction. The loss of potassium is probably greater, in comparison, than calcium or sodium. These ions, however, are easily replaced by proper intravenous therapy. Gage, et al.,¹¹ in 1931, described the tonic effect of insulin on the obstructed gut. This is to be borne in mind, particularly where large amounts of glucose are given, over a prolonged period of time.

Thus, it can be seen that the proper postoperative treatment of this complication of perforated peptic ulcer and peritonitis necessitates a rather comprehensive knowledge of the serum bases, electrolytes, serum proteins and blood chemistry, if a successful campaign is to be waged. Where long continued intubation is necessary, with the patient unable to take food by mouth, serum proteins and ratios demand frequent transfusions of whole or citrated blood. Particularly is this so because the prolonged case soon begins to reveal a toxic degeneration of the polymorphonuclear leucocytes.

Atelectasis calls for the use of oxygen. Best of all is its prevention by administering carbon dioxide inhalations routinely postoperatively. This complication occurred in case one and was very annoying until overcome.

Subphrenic and other abscesses are complications that are to be watched for and dealt with in the usual surgical manner as the patient's condition will permit. The approach under the twelfth rib, advocated by Ochsner, is advantageous in dealing with subphrenic infections.

It will be noted that sulfapyridine sodium monohydrate and sodium sulfathiazole sesquihydrate were used intravenously in case four. It was interesting to note that the blood concentration of the sulfathiazole rose rapidly with a

rapid fall in accordance with the usual findings in the use of this drug. At the time of its administration, peritonitis was the outstanding feature in the patient's condition. A marked clinical improvement followed each administration of sulfonamide intravenously but oral administration of as much as one and one-half grams sulfathiazole every four hours, would not maintain a necessary blood concentration. This is in keeping with Wangenstein's findings of decreased intestinal absorption from obstructed bowel. In case four, eight grams of powdered sulfanilamide were placed in the abdominal cavity just before closing the peritoneum. That this procedure is of value has been borne out by the experience of other workers and, until the complication of wound separation, I believe it was of great value in this case. The opinion of Rosenberg and Wall¹² is that sulfanilamide combines in some way, with the free aminonitrogen of protein degradation products making them unfit as growth media for bacteria and thus literally starving the latter. That sulfanilamide is readily absorbed from open wounds, as well as the peritoneal cavity, has been repeatedly demonstrated.

Case four had the added complication of wound separation. This was produced on the seventh postoperative day when the patient caught hold of the head of the bed and pulled himself up in the bed—coughing at the same time. Most wound separations do occur between the sixth and eighth postoperative days as, at this period, there is no tensile strength to the sutures and healing has probably not progressed sufficiently to withstand much strain—particularly the patients in this age group (sixth decade).

Koster and Shapiro¹³ noted that in a series of disrupted wounds, in which they investigated the serum proteins, that a hypoproteinemia existed with the principal deficiency being in serum albumin. This, obviously, establishes an upset in the normal albumin-globulin ratios. They found that in 86 percent of the cases of wound disruption studied, there was an albumin value of less than 3.75 grams per 100 c. c. blood as compared to values over 3.75 grams and up to 4.41 grams in clean cases without separation. This is borne out in case four reported here whose serum albumin was .92 grams, 1.6 grams, 2.5 grams and 1.07 grams on four different days. Since the serum globulin ranged from 2.7 up to 3.08 grams, a reversal of the normal albumin-globulin ratio was demonstrated. Efforts were made to maintain a near normal ratio by the numerous transfusions and by injecting peptonized milk and eggs through the enterostomy tube.

That some results were obtained can be seen by the consistent rise in serum albumin though never to above 2.5 grams per 100 c. c. blood.

The usual findings are that wound disruptions are more common for upper abdominal incisions than for lower abdominal wounds. Boland seems to have found the incidence of wound rupture in the negro to be about equal for upper and lower abdominal incisions with the latter slightly predominating. However, the great majority of wound separations seen by the writer have been upper abdominal incisions. Particularly is this true in cases of malignant lesions. The transverse incision, as advocated by Goode¹⁴ would seem fundamentally preferable to a vertical incision since that pull of the sutures is at right angles to the direction of fascial fibers lines.

Glenn and Moore¹⁵ state that the mortality of wound disruption continues to be from 22 to 50 percent. In their studies, wound disruption occurred almost three times as frequently in patients with malignant disease than in those with non-malignant pathology. Also they noted a mortality rate of 56 percent in wound disruptions in malignant cases as compared to 18.51 percent in non-malignant ones. The chart these writers have prepared, as to site of incision in wound disruption, is well worth consideration and bears out that upper abdominal incisions more frequently rupture than do lower ones.

Probably the conservative procedure to follow would be the use of silver wires as described by Holman and Eckel¹⁶ in all cases of malignancy and suspected malignancy.

CASE REPORTS

The following cases are reported briefly:

Case I. E. W., white, male, age 42. History of "stomach trouble" for several years characterized by pain after eating, relieved by soda. Patient was stricken by excruciating pain and rigid abdomen about 10:30 p.m., April 29, 1937, and did not come to operation until twenty-two and one-half hours later, at which time he was opened by means of a high right rectus incision and a perforation was found on the anterior aspect of the duodenum just distal to the pylorus. This opening had become partially closed by fibrinous exudate. There was a dirty, straw-colored fluid in the peritoneal cavity which was aspirated. Operative technique was a simple closure of the ulcer with through and through sutures followed by tacking a piece of omentum over the site. A drain was placed in the wound before closure.

Subsequent course: highest temperature was 101 degrees, falling to normal. Second postoperative day, patient developed a left atelectasis which was successfully combatted by administering oxygen for several days. This patient developed a very limited wound separation down to the fascia which rapidly healed. Patient left the hospital in twelve days.

Patient now alive and well at present date (April, 1941).

Comment: This patient made a rather smooth convalescence in spite of his pulmonary complication, even

though twenty-two and one-half hours elapsed between the time of perforation and the time of operation. This may have been due to two factors: (a) the perforation occurred at night on a relatively empty stomach (as contrasted to case four whose perforation occurred in mid-afternoon and who had taken two glasses of salt water and a glass of Bisodol immediately after perforation) and (b) the perforation was very small and had become closed (though insecurely) by fibrinous exudate, thus minimizing peritoneal spillage. I believe the wound separation, even though minor, was due to the drain.

Case 2: M. L., white, female, age 50. History of "indigestion" for twenty years. Previous gastric analysis had revealed "gastric hyperacidity." Stricken with severe, agonizing pain about five a.m., August 27, 1938, board-like abdomen, no vomiting. Operation eight hours after perforation. Large perforation found on the anterior aspect of the pylorus. Very small amount of free fluid in the peritoneal cavity. Convalescence uneventful except that, on the seventh postoperative day, a moderate gastric distention occurred which was quickly combatted by re-establishing a Wangenstein suction. The wound, a right upper rectus incision, healed excellently—no drain having been used. Patient left hospital after eighteen days and is, at present, in good health.

Comment: Here again convalescence was smooth in spite of an elapsed eight hours from time of perforation to time of operation. Again it is noted that the time of perforation occurred at a period coinciding with an empty stomach and minimal peritoneal spillage. The gastric dilatation probably was due to edema at the old ulcer site but was relieved by Wangenstein suction of thirty-six hours. This patient was a visitor in Hot Springs and simply remained in the hospital longer than was actually necessary, rather than return to a hotel, hence, the rather long hospitalization was not actually necessary because of her surgery.

Case 3. M. C., white, female, age 70. History of duodenal ulcer shown by X-ray and history of indigestion consistent with such an ulcer. Patient developed pain in the evening of October 7, 1938, which rapidly increased in intensity until, within a few hours, the pain was excruciating. Abdomen was not rigid but there was marked tenderness just to the right of the epigastrium and under the right costal margin. This patient was nauseated and vomited several times. Because of her age and general debilitated condition, she was deemed too bad a risk for operation and was treated conservatively, in spite of all the misgivings of such a procedure. Her blood count, on admission to the hospital was 3,400,000 red blood cells with 8,600 white blood cells and a polymorphonuclear percentage of 88, next day this was 10,000 white blood cells with 80 percent polys. On October 12, the count was 7,760 white blood cells with 76 percent polys. The patient's temperature ranged intermittently from 99.6 degrees to 102 degrees and 103 degrees until the last two days of hospitalization. X-ray disclosed a deformity of the pylo-duodenal junction with marked spasm and an irregular mass could be felt in this region. The patient's treatment consisted of intravenous fluids and Wangenstein's suction, together with morphia for relief.

She was discharged, after nine days, and is alive and well at present. X-ray three months later was negative as to the presence of the ulcer, though some deformity of the duodenal bulb was present.

Comment: The writer is convinced that this patient suffered a subacute perforation of a peptic ulcer. It is admitted that this is hard to prove and that there are

excellent arguments both pro and con. This was the only case of uncomplicated ulcer that showed an early rise in differential count and this was to be expected, as plenty of time elapsed to allow such a rise.

Case 4. H. W., white, male, age 58. History of "indigestion," relieved by soda or food, for two years. About two p.m., March 27, 1941, while at the horse races, patient was stricken with excruciating pain just to the left of the umbilicus, radiating upward and to the right. He was given two glasses of salt water and a glass of Bisodol at the track and then sent to the hospital. When seen, a diagnosis of perforated peptic ulcer was made and an X-ray (upright position) revealed air beneath the left leaf of the diaphragm. The patient was operated on at once (less than four hours from perforation) and an anterior duodenal ulcer perforation found and closed. There was a huge amount of fluid in the peritoneal cavity, as was expected. Eight grams of sulfanilamide was placed in the abdomen which was closed without drainage. Convalescence was satisfactory until the morning of the seventh day when the patient caught hold of the top of the bed, pulling himself up and coughing. Complete wound separation occurred which was resutured. Thereupon followed paralytic ileus which was overcome finally by a high jejunostomy, subphrenic abscess, diffuse peritonitis and hypostatic pneumonia. Patient lived seventeen days after secondary closure and died. A bacterial culture from the peritoneal fluid revealed a positive growth of staphylococcus albicans. He was given 5 grams of sodium sulfapyridine monohydrate by needle twice, and sodium sulfathiazole sesquihydrate 3.8 grams intravenously twice. The highest blood sulfonamide concentration followed the sulfathiazole, the concentration being 8.6 milligrams per 100 c.c. within thirty minutes but falling to less than 1 milligram in eighteen hours. Sulfathiazole, grams one and one-half, every four hours by mouth, failed to maintain a valuable blood level which was probably due to decreased absorption due to ileus. Blood chlorides were kept fairly constant and within normal range by intravenous fluids. The albumin globulin ratio, however, became reversed and remained so throughout, in spite of repeated (seven) transfusions and other measures. Following the enterostomy, concentrated Hartman's solution was given twice. The ileus was overcome and patient had numerous evacuations from the bowel in the normal fashion. He was given peptonized milk and egg through the enterostomy. Patient finally died of what was believed a cardio-respiratory death, seventeen days after his wound rupture.

An autopsy revealed that the obstruction had been overcome; the plastic effects of peritonitis were noted; a subphrenic abscess, though small, was present. The pleural cavities on each side contained about 1,500 c.c. of clear fluid and there was a minor degree of atelectasis in each upper lobe.

Comment: This case had a bad outlook to begin with in the fact that he was given so much to contaminate his peritoneal cavity. Secondly, his wound rupture decreased or removed what chance he apparently had to survive. Next, the rapid succession of complications, all of them serious, further decreased the man's chance of survival. The fact that he survived seventeen days seems to the writer to be a tribute to the value of applying physiological principles to the further treatment of the case.

Conclusions: The object of this paper has been to review and discuss, briefly, advances made in the treatment of perforated ulcer and

its complications. The four cases were mentioned as illustrative of certain of these complications and the value of various therapeutic agents.

The fact that early diagnosis is necessary and immediate treatment is necessary is stressed. It is plain that complete cooperation is necessary between the laboratory worker and the surgeon in conducting the postoperative care of the patient.

It is obvious that the various electrolytes and serum proteins are of great importance, both prognostically and therapeutically.

The value of bacterial culture from the peritoneal fluid should be given greater consideration as it gives a forecast of the chance of survival as well as informing the surgeon of the bacterial infection that he must contend with.

The ideal to be obtained in its ultimate analysis is the avoidance of postoperative complications by anticipating and preventing them. In this respect, the writer believes that not only in perforated ulcer, but in all abdominal surgery, the routine administration of morphia every four hours, the use of the heat tent and parenteral electrolytes will lessen the incidence of complications and offer a better chance for a smooth postoperative convalescence.

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A MESSAGE TO THE MEMBERS OF THE AMERICAN MEDICAL ASSOCIATION

For some ten years the physicians of the United States have been subjected to a series of stresses such as have disturbed the orderly progress of medical science in no previous period of similar length. In 1860 Oliver Wendell Holmes wrote:

"The truth is that medicine, professedly founded on observation, is as sensitive to outside influences, political, religious, philosophical, imaginative, as is the barometer to the changes of atmospheric density."

The depression of 1929, the evolution of the Social Security Act, the first Wagner bill, the development of hospitalization and medical care insurance, the enrollment of a third of the active medical profession in the armed forces, and now the Wagner-Murray-Dingell bill represent a series of provocative crises. Each of these challenges was met by the House of Delegates, the Trustees and the officers of the Association with clearly defined statements of policy which the Association has disseminated widely. Under these policies the extension of medical service has proceeded steadily and everything possible has been done to maintain the quality of medical education and medical service at the high standard that has been our ideal. The continued pressure of the years has been climaxed by the Beveridge report, the report of the National Resources Planning Board and the introduction of the Wagner-Murray-Dingell bill. This comes when every physician not in the armed forces is giving of himself unstintedly without thought of time or physical capacity.

Today strange social philosophies pervade the radio, the press and the periodicals. Panaceas for medical problems are proffered by innumerable prescribers. Some preach distrust of medical organization, cast doubt on the loyalty of our leaders, sow dissension in our membership! These activities are no doubt a reflection of anxieties and fears. And they appear at a time when a united, loyal, solidly organized medical profession is more needed than at any previous time in our history! When our representatives appear before legislative hearings they are entitled to the loyal, enthusiastic, unified support of the constituent and component societies of the American Medical Association.

In some areas there are attempts at reorganization of the county medical society on a strictly

business basis; attempts are being made to organize small groups of the states into sectional cliques; before the House of Delegates of one state a delegate actually urged a united opposition to the Southern states; here and there physicians, apparently inspired by lay employees or by the urging of outside agencies, would pour the funds of county and state medical societies, swollen by special assessments, into "public relations," as if this were some new and potent magic; there are occasional demands that the medical profession "unionize" and affiliate with one or the other of the major labor organizations. The far-seeing Oliver Wendell Holmes was right: physicians are "sensitive to outside influences, political, religious, philosophical, imaginative."

Now what are the facts? The trend of public thought is quite definitely against any such expansion of the Social Security Act as the Wagner-Murray-Dingell bill contemplates. The Council on Medical Service and Public Relations has been organized, has developed a program, has stated its policies, has secured a full time secretary, has expanded sources of information on legislative activities, is participating in public relations for the Association. The Board of Trustees has organized for suitable representation at any hearings that may be called on legislation affecting the medical profession. The publications of the Association have reached the highest peak in their history in circulation and effectiveness. A poll proves that a majority of Americans interviewed consider the American Medical Association an organization interested in the advancement of medical science, an organization devoted to the approval of that in medicine which is sound and exposing that which is fraudulent—what the experts call a "favorable symbol." And all this accomplished at a time when the employees of the Association have been reduced by one fourth by war activities or call to the armed forces, and when many others are likewise giving largely of their time to war activities.

The Board of Trustees pledges itself anew, as do the officers and employees of the Association, to do their utmost to carry out and to implement the principles, the policies and the mandates of the House of Delegates. To some 55,000 physicians who are in the armed forces the Board pledges all that the Association can do to maintain for them a medical profession free from the interference of political control. The Board is convinced that the House of Delegates will also do its utmost to hold the traditions of American-

ism and American medicine inviolate until the physicians who are now with the armed forces return and themselves participate in determining the future of American medicine.

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COMMUNIQUE

January 24, 1944

To the Editor:

If you don't think you'll need a pulmotor to assist you over the first shock of hearing from me after my neglect in writing, I'll give a little information about my whereabouts for the nonce, which is the U. S. Naval Air Technical Training Center, Memphis. Inasmuch as the man that passes out naval personnel assignments has just blown lustily down my neck and gelatinous spine, I am not certain of future addresses. I expect to get over home before doing any extensive traveling and if so will see you if at all feasible.

Our duties here have been altogether dispensary work. For the past three months have had a bad "cat fever" epidemic and we have been extremely short-handed with doctors and we have been working quite hard and for long hours. Have been here since February 26th, last.

Last week I was admitted to the Naval Hospital with broncho-pneumonia (now cleared and this is my first day out of bed). Since being here the above-mentioned orders arrived and I suppose they will be re-served on returning to my station after being discharged from the hospital. I can't say what they are for but I can say that they are now showing over the country an exciting picture that tells of the exploits of the busy "B's" (pun intended). At any rate, I think it best, in the interest of my frayed and jangled nerves, that I do not go to see "The Fighting Seabees."

I promise to keep in touch with you better from here on out.

Sincerely,

Chas. S. Paddock,
 Lt. Comdr., M. C. USNR.

COMMUNIQUE

January 18, 1944.

To the Editor:

Your letter of December 27th received and I was very glad to hear from you and especially the news from Arkansas. You are quite right about me being with a surgical unit as I still am; had to use the other unit designation when I wrote you the last letter. I am with a portable surgical hospital meaning we are supposed to carry everything on our backs for distances then set up for definitive surgery. It is the newest thing in the organization of the medical services of the armed forces. You will note in the upper right-hand corner the unit designation. Sort of rugged, I'd say.

The reason for my letter back from Camp Maxey was that we were on the alert back in the USA and I had no idea where we were bound for, therefore, decided it useless to continue until more or less permanent APO was established. Your mail has a tendency to go all around the world before coming to you unless there is the proper unit designation on it; I've had the experience to know this thing. I shall be glad to receive The Journal when you send it to me.

Major Johnston's unit was nearby here when I first came in but have reason to believe they are not here now. I did not have the pleasure of meeting him as things even at similar APO's can be miles and miles apart, but if ever I meet with his organization I will look him up.

Everything is quiet here, however, it is that way at times when it gets real noisy, and you jump into a hole anyway. It makes you feel better to be in a hole when there isn't too much water in it. Otherwise we are living the life of Reilly. Am glad to hear that the hospital in Pine Bluff is functioning.

Must close now, again, I appreciate your nice letter and hope you will see fit to sometime again drop a line in.

Wishing you the best of luck, I remain

Sincerely yours,

Hunter A. Causey, Capt., M. C.

COMMUNIQUE

February 8, 1944.

To the Editor:

Random Thoughts for January arrived today and I want you all to know that not only do the boys from Arkansas enjoy the little slips of paper that are included as all my fellow officers have enjoyed this one. * * * Keep up the good work and let me hear from you often.

Sincerely,

Ewing M. Nixon, Capt., M. C.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

OUR national experience with tuberculous veterans of the last war has been unfortunate. Sadder still would be a repetition involving the men and women fighting World War II. This paper, addressed originally to health officers, challenges every physician whose practice embraces a tuberculous veteran or the family of one.

TUBERCULOSIS AMONG VETERANS

During first World War inductions, knowledge and facilities for diagnosis were insufficient to screen out many men suffering from tuberculosis, particularly presymptomatic disease. Thus, many active cases entered the Army. Hardships of training and combat produced still more. After the war, care of tuberculous veterans fell to the newly organized Veterans' Bureau. Hospitals and sanatoria were erected. The service became a major medical activity of the Bureau, and of its successor, the Veterans' Administration. As early as 1923, 23,653 tuberculous veterans were admitted to treatment in one year. At first, care was limited to tuberculosis connected with military service. Subsequently, cases with disease unrelated to military service became eligible. As a result, tuberculosis admissions have continued numerous. During fiscal 1942, after almost a quarter century, hospital admissions numbered 9,658. Over 300,000 such admissions and re-admissions have accrued in hospitals of the Veterans' Administration or other government, state or civil institutions since the last war.

The government has spared no efforts or funds in erecting and equipping modern hospitals and in providing adequate medical personnel. In March, 1942, there were 5,217 beds to meet current needs, embracing tuberculous veterans of the present war and including tuberculosis beds in veterans' psychiatric hospitals. Besides having all costs of hospitalization and transportation to hospitals paid, tuberculous veterans also receive compensation payments scaled from \$8 to \$100 per month, based on varying grades of dependency and service-connected or non-service-connected disability. Men treated at home may qualify for an additional \$50 per month payable to the wife or other attendant. These provisions have tempted many to discontinue hospital care and attempt a cure at home.

Standards of operation in veterans' hospitals are generous. In 1942, excluding overhead, the per diem cost of operation was \$4.37 per patient and the total direct costs of treatment approached \$8,000,000. Compensation of World War I veterans with partial or total disability due to tuberculosis, whether or not service-connected, amounted to approximately \$40,000,000 during that fiscal year. Such veterans then still numbered 63,000, and exceed by many times the number accepting hospital care. Disability payments over the last 25 years aggregate about one billion dollars.

Despite the admirable services available to tuberculous veterans, the experience of their hospitals has been unfavorable. Thus, in 1942, of the 9,854 cases discharged from these hospitals, only 1.9 percent were designated "arrested" at discharge; 0.3 percent "apparently arrested," and 0.8 percent "quiescent"—a bare total of 3 percent medically rehabilitated. The remaining discharges included: "condition improved" 32.7 percent; "condition unimproved" 28.9 percent; "dead" 19.5 percent; and "condition not stated" 16.0 percent. The vast majority were obviously not ready for release. So-called "improved" cases represent, predominantly, patients with unstable lesions, a large proportion leaving the hospital without authorization or consent. Thus, the Veterans' Administration itself classified the hospitalization of 58 percent of the cases as "incomplete." These 1942 figures are rather typical, though somewhat worse than those of earlier years.

Exact comparisons among various sanatoria as to results of treatment on the basis of such crude figures are impossible, particularly now when World War I veterans admitted are older men, usually with chronic disease. Of recent admissions, only 4 percent were "incipient" cases, 22 percent "moderately advanced" and 74 percent

"far advanced." Even so there is a painful contrast between the results with veterans and those achieved in well managed state, municipal, and private sanatoria. In a 1933-34 survey of tuberculosis hospitals and sanatoria in the United States by the American Medical Association, patients discharged with tuberculosis "arrested," "apparently arrested," or "quiescent," accounted for 29 percent of all discharged. Among Michigan State sanatoria from 1930 to 1934 discharges included 61 percent in these three groups. At Mount McGregor Sanatorium of the Metropolitan Life Insurance Company, of males discharged between 1919 and 1936, and excluding incipient cases, 48 percent were in comparable categories. Even for cases far advanced on admission, the proportion was 34 percent.

This deplorable situation among tuberculous veterans has not developed from lack of desire to help the men. Everyone concerned aimed at optimum care. The chief failure was by legislators and others interested in veteran welfare to appreciate fundamental conditions necessary for effective treatment. In part, outside pressure was brought to bear to liberalize financial provisions. These measures actually have minimized effective control over the movement of the tuberculous. Veterans, not subject to ordinary hospital restrictions, come and go almost at will, regardless of their condition and against medical advice. Patients have been readmitted as many as 24 different times. Six to 8 admissions of the same man are common despite official effort to educate and persuade patients to complete their hospital care, and measures to exclude offenders from immediate rehospitalization. Much of the discipline essential to success in treating tuberculosis is lacking. Indeed, laws and practices have so evolved that it often financially benefits men to leave the hospital or avoid it altogether. This creates an impossible situation, undermining morale of veterans and professional staff alike.

More serious than mere failure to rehabilitate the patient, discharge before cure exacts its toll on the nation. It has allowed thousands with communicable tuberculosis to return to civilian communities, to live at home or travel about under little or no medical supervision. State and local health officers have assumed little responsibility for men traditionally regarded as wards of the federal government. Few patients have recovered; most have constituted an army of discouraged men spreading tuberculosis in their home communities.

Administration authorities and veterans' leaders are recognizing the need for a remedy, be-

ginning with a drastic change in viewpoint. Specific improvements are being considered and necessary legislative measures will be debated. The American Legion is launching a campaign through its local branches to see that veterans resume and continue hospital treatment until discharged with medical approval.

What is to be done? First, new controls must render liberal benefits medically effective, preventing the drifting of tuberculous veterans until the disease is "arrested" or, at least, not a menace.

Second, the medical profession must cooperate with the Veterans' Administration in the follow-up of tuberculous ex-patients. The Administration has indicated that it will release information to state and local health officers, and routines for getting such reports are imperative. Men still in need of sanatorium care who will not stay in veterans' institutions should be hospitalized in state or local sanatoria, with legal power invoked where necessary. Each man's circle of contacts should be thoroughly combed for additional cases.

Finally, a genuine effort must be made to protect the large crop of tuberculous veterans inevitable from the present war. It is likely that the Veterans' Administration will function under regulations and procedures governing the care of veterans of World War I. Already, many of the tuberculous veterans of the new war show the same restlessness and abandonment of hospital care which have produced calamitous results among the older men. With new cases already numerous, the stage may be set for another great medical tragedy. Lack of discipline and mistaken generosity may not only take their toll of young men who deserve to get well and resume useful lives, but may seriously delay control of tuberculosis in the general population—unless we act!

Function of the Health Officer in the Control of Tuberculosis among Veterans, Louis I. Dublin, Ph.D., *Amer. Jour. of Pub. Health*, Dec., 1943.

PENICILLIN FOR CIVILIAN USE!

Penicillin is under strict allocation control by order of War Production Board (Order M-338). One-half is supplied to the Army, the remainder to the Navy, the Office of Scientific Research and Development and to the Public Health Service.

Civilian physicians may obtain a supply in cases of REAL necessity by:

1. Preparing a brief resume of the case,
2. Telephoning or telegraphing,

Dr. Chester S. Keefer, Evans Memorial Hospital,
65 E. Newton St., Boston, Mass.

THE JOURNAL

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EDITORIALS

ACTION IN TIME MEANS LIFE

C. C. LITTLE, ScD.

Managing Director of the American Society
for the Control of Cancer

It has been stated that cancer is the most curable of the fatal diseases. That is an interesting statement and is not a contradiction of itself, as it might at first seem to be. Its justification lies in the nature of cancer itself—for cancer in its early stage is localized, limited, and capable of being completely removed or destroyed.

Cancer in its late stages is as sinister as a disease can be. It is widespread and has invaded surrounding tissues with ill-defined irregular strands of abnormal growth. If untreated and unchecked, cancer is uniformly and universally fatal. It is this grim fact that brings out the contrast between early and late stages of the disease.

The picture, however, is far from being a gloomy one. Each year more and more people are learning that "time" is the key word in cancer control. Each year thousands more people are coming to their doctor with very early signs

and symptoms that may mean cancer. As a result they are being treated in time to prevent cancer or to cure it if it has started. The value of annual or semi-annual physical examination is becoming clearer to an ever-increasing number of men and women. The Women's Field Army of the American Society for the Control of Cancer is growing yearly at a faster rate. Today three hundred thousand women throughout the United States are enlisted in the fight against cancer—the fight to bring knowledge and confidence into every home in the country.

Cancer Prevention Clinics—where perfectly well persons report periodically for a physical "check up"—have been established in some cities and are doing excellent work. The idea will spread and grow. Lives will be saved, suffering avoided. Death will be cheated. Americans of the future will visit such clinics as a matter of routine.

It is well when the world is darkened by the fierce storm clouds of war to remember that there are men and women working quietly but tirelessly to allay fear and to bring peace and hope to hundreds of thousands of people—to your friends and mine—to your family and mine—perhaps to you and me ourselves.

For thirty years the American Society for the Control of Cancer at 350 Madison Avenue, New York City, has been the leader in this campaign. It will gladly provide, without charge, information which you may desire. It asks you to enlist in the fight against cancer for your own sake as well as for those whom you may be able to help. Do not delay. Remember that in cancer "action in time means life."

THE WAGNER BILL

Opposition to the Wagner bill by physicians reached a peak some time ago. It seems that there is a tendency now on the part of physicians to optimistically view the outcome and often is heard the statement that the "bill can not pass." Whether this be a true appraisal of the situation or not is of slight consequence. In the minds of the persons who sponsor this legislation no such thoughts exist. They are working to the end that the necessary votes are secured in Congress for its passage. It may well be that this bill will not pass. If not, it is certain that similar legislation will be introduced, or a compromise bill, and surely physicians everywhere are familiar with the effect so-called compromise bills may have on the practice of medicine. The opponents of medical practice as it now exists have no intention of calling off the battle. Rather may we

expect to see their efforts doubled and redoubled in the days ahead.

It seems that the needed strength for fight does not spring from the profession. Possibly we are tired. Yet we cannot now fail to fight for ideals. In spite of our weariness, our lethargy, there is no other choice. We may be comforted in the fact that we do not fight this battle alone. We already have the support of other professions and groups. It is the duty of the medical profession to show that government control of the practice of medicine is but the experiment to establish precedents and procedures that will subsequently involve other groups. Once this process is begun there will be no stopping the forces which seek to destroy the democracy our colleagues and sons are now fighting to preserve.

Certain practical considerations should guide us at this time. These will require much of our time and energy. Unless we are willing to give of ourselves in this fight, the cause is indeed lost.

The public must be educated. They are willing to listen. They want our country to remain a democracy. They expect a continuation of free enterprise. If they understand the logical outcome of the forces now in motion, how these will soon affect their businesses, they will rally to our support. It is but for us to bring them the message, to give them an understanding of the ultimate effect of the activities of our antagonists.

People believe in their personal physician. They know he has a personal interest in their illness. Any change in this relationship is unwelcome. But the public does not know that such a change may take place. It is our duty to inform them.

There is a need that the medical profession give itself the benefit of searching case study. The scientifically-trained minds of the profession should seek the cause behind the many changes advocated in the practice of medicine, should give earnest thought to remedies which the profession itself should apply. There is no doubt that courageous, self-sacrificing study; diligent application of knowledge and intelligent effort by the profession will profit the public and the doctors.

ADDRESSES WANTED

Response of the members to the request for addresses of members in service in the January Journal was good. There remain, however, too many of our members whose military addresses are not known to The Journal. It will be an appreciated help if members will furnish the present

military address or send in information which will be of help to The Journal in securing the addresses of the following:

Glen G. Hairston, Prescott
William M. Kober, Little Rock
Harlan H. Hill, Little Rock
Horace L. Fuller, Little Rock
Hollace D. Fowler, Little Rock
John P. Eaton, Little Rock
Donald W. Dykstra, Little Rock
Jess Paul Champion, Little Rock
Thomas D. Alford, Little Rock
H. H. Smith, Little Rock
Julius B. Askew, Little Rock
Julius K. Sheppard, El Dorado
J. H. Pinson, El Dorado
R. E. Smallwood, Hot Springs

EDITORIAL COMMENT

HONORARY MEMBERSHIP

The attention of county medical societies is directed to the provisions concerning election to honorary membership in the state society. Honorary membership in the state society can only be conferred by the House of Delegates in annual session each year upon due nomination by the Council. To be eligible for such nomination and election, a member, (1) must be 65 years of age, (2) have been a member in good standing for the 15 preceeding consecutive years, (3) must be in good standing at the time of nomination, i. e., the current year's membership assessment must have been paid, (4) must have been elected a honorary member of his county medical society, and (5), effective with the annual session of 1938, must have paid his annual membership assessment in each year prior to March 1st. The office of the state secretary should receive proper notification sufficiently in advance of the annual session to permit a check of the records and to prepare the names for submission to the Council and to the House of Delegates.

COMING MEDICAL MEETINGS

New Orleans Graduate Medical Assembly,
New Orleans, March 6th-9th.

Regional Session, American College of Surgeons, Tulsa, Oklahoma, April 4th.

Arkansas Medical Society, Little Rock, April 17th-18th.

American Medical Association, Chicago, June 12th-16th.

PROCEEDINGS OF SOCIETIES

Independence County Medical Society has elected the following officers: President, W. P. Gray, Batesville; Vice-president, V. D. McAdams, Cord; Secretary-treasurer, F. Q. Wyatt, Batesville; Delegate, W. J. Ketz, Batesville, and Alternate, O. J. T. Johnston, Batesville.

The Craighead-Poinsett County Medical Society was addressed February 3rd by E. J. Horner, Jonesboro, on "Progress of the Arkansas Blood Bank," and by Geo. R. Livermore, Memphis, on "Some of the Urological Problems of Interest to the General Practitioner."

J. H. McCurry, Secretary.

Columbia County Medical Society has elected the following officers: President, W. H. Horn, Magnolia; Vice-president, T. S. Jordan, Magnolia; Secretary-treasurer, T. H. Jones, Waldo; Delegate, J. H. Wilson, Magnolia, and Alternate, W. P. Cooksey.

The Lawrence County Medical Society was addressed February 8th by Capt. Haizlip, M. C., A. U. S., Walnut Ridge Airport. The following officers have been elected: President, J. L. Merrell, Walnut Ridge; Vice-president, R. S. Faircloth, Walnut Ridge; Secretary-treasurer, Chas. D. Tibbels, Black Rock; Delegate, J. C. Land, Walnut Ridge, and Censor, T. Z. Johnson, Walnut Ridge.

Chas. D. Tibbels, Secretary.

The Sebastian County Medical Society was addressed February 8th by C. L. Seaman, Fort Smith, "Venereal Disease Control in Sebastian County," with Capt. Harry Sklar, Camp Chaffee, and E. J. Easley, Little Rock, discussing the presentation.

D. W. Goldstein, Secretary.

The Benton County Medical Society met in dinner session at Rogers February 10th for a program of case reports by Guy Hodges, W. A. Moore, Clyde McNeil and Geo. M. Love.

Geo. M. Love, Secretary.

Randolph County Medical Society has elected the following officers: President, J. E. Smith, Reyno; Vice-president, W. E. Hamil, Pocahontas;

Secretary-treasurer, M. A. Baltz, Pocahontas; Delegate, W. E. Hamil, and Alternate, J. R. Loftis, Pocahontas.

White County Medical Society has elected the following officers: President, S. J. Allbright, Searcy; Vice-president, Porter R. Rodgers, Searcy; Secretary-treasurer, D. W. Sloan, Beebe; Delegate, M. C. Hawkins, Jr., Searcy, and Alternate, C. M. Peeler, Pangburn.

The Miller-Bowie Counties Medical Society was addressed January 28th by A. C. Kolb on the work of the State Hospital.

H. K. Abrams, Secretary.

Grant County Medical Society has elected the following officers: President, O. R. Kelly, and Secretary-treasurer, John W. Cole.

Little River County Medical Society has elected the following officers: President, E. W. Yates, Foreman; Secretary-treasurer, C. A. Harding; Delegate, N. W. Peacock, Ashdown, and Alternate, E. W. Yates.

Greene County Medical Society has elected the following officers: President, J. A. Dillman; Vice-president, Earle H. McKelvey; Secretary-treasurer, W. McD. Lamb; Delegate, R. J. Haley, and Alternate, W. E. Ellington.

Arkansas County Medical Society has elected the following officers: President, M. C. John; Vice-president, A. H. Fowler; Secretary-treasurer, S. A. Drennen, Stuttgart; Delegate, R. H. Whitehead, and Alternate, E. B. Swindler.

Washington County Medical Society has elected the following officers: President, J. P. Delaney; Vice-president, W. A. Fowler; Secretary-treasurer, Ruth Ellis Lesh; Delegate, Ruth Ellis Lesh, and Alternate, W. A. Fowler.

I. F. Jones, Fort Smith, addressed the Washington County Medical Society February 1st on "Caudal Anesthesia in Obstetrics."

Miller County Medical Society has elected the following officers: President, H. E. Murry; Vice-president, W. Decker Smith; Secretary-treasurer, H. K. Abrams; Delegate, R. R. Kirkpatrick, and Alternate, B. C. Middleton.

Jackson County Medical Society has elected the following officers: President, E. L. Watson, Newport; Vice-president, C. R. Gray, Newport; Secretary-treasurer, J. B. Ivy, Tuckerman; Delegate, H. V. Walker, Newport, and Alternate, A. L. Best, Newport.

Pope-Yell County Medical Society has elected the following officers: President, A. B. Tate, Sr., Russellville; Vice-President, Ellis Gardner, Russellville, and Secretary-Treasurer, W. O. Young, Russellville.

Lonoke County Medical Society has elected the following officers: President, S. S. Beaty, England; Vice-President, W. B. Crowgey, Scott; Secretary-Treasurer, O. D. Ward, England; Delegate, S. S. Beaty, and Alternate, A. C. Watson, Benton.

The Miller County Medical Society was addressed February 18th by W. Decker Smith, "Gastrosocopy as an Aid to Diagnosis of Gastric Lesions," and R. C. Cross, "Syphilis and Pregnancy."

H. K. Abrams, Secretary.

Ashley County Medical Society has elected the following officers: President, M. C. Crandall, Wilmot; Secretary-Treasurer, L. C. Barnes, Hamburg; Delegate, M. C. Crandall, and Alternate, A. E. Cone, Portland.

Nevada County Medical Society has elected the following officers: President, T. W. McDaniel, Boughton; Vice-President, W. B. H. Pool, Bodcaw; Secretary-Treasurer, J. W. Kennedy, Prescott; Delegate, A. S. Buchanan, and Alternate, J. B. Hesterly.

Benton County Medical Society has elected the following officers: President, A. J. Harrison, Springdale; Vice-President, C. S. Wilson, Siloam Springs; Secretary-Treasurer, Geo. M. Love, Rogers; Delegate, C. S. Wilson, and Alternate, L. L. Scott, Siloam Springs.

Pulaski County Medical Society has elected the following officers: President, Carl A. Rosenbaum; Vice-president, J. N. Compton; Secretary, Elizabeth D. Fletcher, and Treasurer, R. M. Blakely.

PERSONALS AND NEWS ITEMS

Geo. S. Atkinson, formerly of Morrilton, is now located in Florence, Colorado.

Maj. S. B. Thompson, Camden, is now on duty with the 69th General Hospital, Camp Swift, Texas.

George C. Burton, Bald Knob, has moved to Ottawa, Illinois.

L. J. Kosminsky, Texarkana, attended the Child Welfare Conference of the American Legion at Houston during January.

Capt. H. K. Carrington, Magnolia, is now on duty with an evacuation hospital overseas.

Lt. Robert G. Young, Little Rock, is now on duty overseas.

Lt. Chas. P. Harris, Jonesboro, has been ordered to active duty and assigned to Medical Field Service School, Carlisle Barracks, Pennsylvania.

J. Kenneth Thompson, Fort Smith, now in desert maneuvers, has been promoted to captain.

Col. Howell Brewer, Hot Springs National Park, has been admitted to the Army and Navy General Hospital after a long period of service overseas.

Carl L. Rosenbaum, Little Rock, addressed the Regional Meeting of the Women's Field Army of the American Society for the Control of Cancer at Memphis, January 31st.

W. A. Snodgrass, Jr., formerly of El Dorado, has opened offices at 839 Donaghey Building, Little Rock.

Capt. W. L. Shippey, Fort Smith, who has been in service overseas for the past year, is now at Winter General Hospital, Topeka.

Lt. Col. James W. Branch, Hope, is now stationed overseas.

Capt. W. E. Turner, Jr., Piggott, has been transferred to Camp Atterbury, Indiana.

Chas. R. Walton, Veterans Administration, has been transferred to the Augusta, Georgia, Facility.

Capt. James W. Lamb, Paragould, is now stationed overseas.

Capt. Hollis H. Buckelew is now stationed at Fort Wm. H. Harrison, Helena, Montana.

Rogers Hedrick, Booneville, now stationed at Fort Barrancas, Florida, has been promoted to major.

D. L. Owens, Harrison, attended the recent sessions of the Federation of State Examining Boards in Chicago.

W. L. Bunch, Jr., U. S. P. H. S., Little Rock, has been transferred to Isolation Hospital, New Orleans.

Capt. W. M. Woods, Huntington, is now stationed at Sermour Johnson Field, North Carolina.

Capt. W. O. Loftis, Pocahontas, is now stationed at Southwestern Proving Grounds, Hope.

Lt. Phillip T. Cullen, Little Rock, is now stationed at Warner Robins Air Depot, Georgia.

F. Walter Carruthers, Little Rock, addressed the Sheridan Rotary Club, February 4th, on "Crippled Children."

"Thoracic Surgery After World Wars I and II," an editorial by Maj. J. K. Donaldson, Little Rock, appeared in the December, 1943, issue of The American Journal of Surgery.

F. Walter Carruthers, Little Rock, addressed the North Little Rock Lions Club recently in the interests of the Infantile Paralysis Campaign.

Fred Hames, Pine Bluff, conducted a diagnostic cancer clinic at El Dorado, February 17th, under the auspices of the Union County Medical Society and the Women's Field Army.

Brooks Teeter, Russellville, now stationed overseas, has been promoted to major.

H. E. Mobley has been elected Vice-President of the Morrilton Chamber of Commerce.

Earle H. Hunt and G. R. Siegel, Clarksville, have been appointed co-chairmen for the Johnson County Red Cross Campaign.

W. C. Magness, Camden, has been appointed lieutenant, Medical Corps, Army of the United States, and assigned to Carlisle Barracks.

F. A. Corn, Lonoke, now stationed at Hendricks Field, Florida, has been promoted to major.

Capt. A. W. Thompson, Bentonville, is now stationed overseas with a combat engineer regiment.

Lt. Col. Joseph O. Boydstone, Hot Springs National Park, is now stationed overseas.

Capt. W. L. Shippey, Fort Smith, is now hospitalized at Winter General Hospital, Topeka, Kansas.

H. K. Abrams has been transferred from Texarkansas as P. A. Surgeon (R), U. S. P. H. S., to the Office of Malaria Control in War Areas, Atlanta, Georgia.

Maj. Allen R. Russell, Pine Bluff, and Capt. Louis K. Hundley, Fayetteville, are now on duty overseas with a station hospital.

Paul S. Lanier, Round Pond, has accepted appointment as resident to the Leo N. Levi Memorial Hospital, Hot Springs National Park.

Majors J. D. Johnson, Fort Smith, and Sam Phillips, Little Rock, have been assigned to a general hospital for overseas service.

Geo. W. Parson has been elected secretary-treasurer of the Miller County Medical Society.

"Underwater Therapy at Spas," by Lt. Col. Euclid M. Smith, Hot Springs National Park, one in a series of articles on American Health Resorts, appeared in the February 19th issue of The Journal of the American Medical Association.

Joe W. King, Helena, is now in service overseas.

Capt. H. C. Sims, Blytheville, has been transferred to Fort Custer, Michigan.

RANDOM THOUGHTS OF THE SECRETARY

February 6th. Again, 3,000 miles of gas-rationed motoring having been traversed, we travel to Burns Gables only to find that institution closed for repairs. So adding miles and visiting a pet eating place, Fayetteville's Washington Hotel, where the same good hot rolls are to be had. Then down Highway 71 in good spirits as on many an occasion in days gone by, the radio giving entertainment along with cause for much thought over today's situation on the Italian beachhead.

February 7th. Comes Captain Miles Foster from Fort Leonard Wood way who has obtained a 15-day leave through herniotomy indicating that leaves are not the VOCO's there that Stanley Gates gets at Chaffee. Miles brings word of Dick Miller but cannot boast the physical prowess to carry out Dick's greetings.

February 8th. Tonight we have venereal disease control discussed at the county society meeting from the state (Easley), county (Seaman) and army (Sklar) levels, an informative discussion revealing the detail with which the public health fellows are endeavoring to combat the problem. There being no bachelor doctors present, no one is observed peering into Seaman's little black book which lists many names.

February 12th. It becoming known that we are to fly to Chicago tonight, we are much impressed with the number of acquaintances who marvel that we would make such a trip, the unfortunate Memphis plane disaster being but a day or so ago. Thus, it is again demonstrated that the average man takes to the newer mode with much deliberation and purposeful delay. Had there been a catastrophic train wreck this week, we doubt that any one would have mentioned this to us prior to our stepping aboard a Pullman.

February 13th. Today there is much discussion over the activities of the medical profession in public relations and publicity, Indiana's new medical organization and the western states' plan being fully presented to a net result of the conference saying we think the national organization should establish a two-way information office but if it does not, we shall do so. Meeting D. L. Owens, a visitor, awaiting the state board meeting. Glad to obtain the news of the Council's ruling that the University of Arkansas Medical School will receive a Class A rating. Boarding the plane knowing in advance that we shall be forced to obtain other transportation at Saint Louis because of weather conditions and the story of how we made the rest of the trip is additional evidence in support of the campaign to "Let a Serviceman Travel."

February 21st. After two days we get a phone call through to Shippey who has circumnavigated the globe in his military service to reach Winter General Hospital in Topeka yet seems not to have fully learned his lesson about going AWOL although he insists that this time he had a week-end pass.

February 22nd. We thought we had seen that excitable little dermatologist, Goldstein, all jittery on many an occasion, but then, we had never seen him become a grandfather as he did this morning.

AN OPEN LETTER TO U. S. SENATORS

Bronxville, New York, December 6, 1943.

Honorable Sirs:

Medicine, little interested in the sound and fury of politics, may find itself under Wagnerian control, a pawn of bureaucrats. Reduced to a trade, its efforts shuffled about by party office holders, it carries a joker in its pack. Be ready, gentlemen, to receive its demand for a forty-hour week.

Is any deluded son of Nestor in Washington so naive as to think that one hundred thousand intelligent medical men will continue driving through their days and nights, their Sundays and your holidays, while all other government servants, as well as miners, firemen, and street sweeps, cruise along on an eight-hour schedule?

Prepare, my dear Senators, to furnish your people with two hundred thousand additional doctors for a three-shift daily service. Prepare to finance students through a ten year course at fifteen hundred dollars for each, annually. A neat figure, that! Is it three hundred million, by any chance? And every year?

Plan to erect five hundred hospitals, each two hundred beds, at five thousand dollars a bed, a little item of half a billion dollars. Then throw millions, about sixty of them, into new medical schools, after you have learned to build them (they differ from post offices), and find, if you can, in this great round world, teachers to staff these institutions.

Be prepared, at the end of an eight-hour service, to have your state appointed doctor walk out from a pneumonia crisis in your home, then wait for X or No. 16 of the graveyard shift to carry on or finish the work at hand.

When an acute abdominal emergency occurs in your family, do not be surprised to find the best surgeon you know lost on his way to an unknown golf course, his government scheduled hours to begin at 4:00 P. M.

Senators, learn to pray—for your friends and for your families.

Richard Charlton,
Westchester Co. Med. Soc. Bull.

OBITUARY

ELBERT AMSDEN BING, age 67, died at his home in Marshall February 2nd. Born in Illinois December 10, 1876, he graduated from the Saint Louis University School of Medicine in 1906. He first located at Gilbert and came to Marshall in 1935 where he operated a hospital. A member of the Searcy County Medical Society, of which he had been president and its delegate to the state society on several occasions, he was also a past president of the Ninth Councilor District Medical Society. Surviving him are his wife and two sons.

THE HOME FRONT *

You Doctors on the Home Front
Are doing more and more
Office work and night calls
Than you ever did before.

Buying bonds and more bonds,
Giving here and there,
Yes, you Doctors on the Home Front
Are doing your full share.

Most of you remember
How you served in World War I
And wishing now, you had the chance
To be in uniform.

This may not be the job you choose,
It's not an easy one,
But for those who serve our Men in Arms,
You, here, must carry on.

Just when you thought the time had come
To turn to younger men,
The heaviest of your burdens,
You took them up again.

You've more of work and less of play,
It's harder for you, too.
You catch less fish and shoot less quail,
Take fewer trips, it's true.

But the Doctors serving at the Front
Have put their trust in you.
They know you'll keep the homes they left,
Worthwhile to come back to.

So I salute the Home Front—
Your wives know what you do.
Our hopes and prayers are with our sons—
Our pride and faith—with you.

—Juliette G. Moulton.

COMMUNIQUE

February 10, 1944.

To the Editor:

I received your nice informative letter a couple of days ago and enjoyed it immensely. I was, however, quite flabbergasted to discover in your letter the fact that I had not written you. You must believe me when I say that I have started several times to drop you a line and no doubt thought that I had done so but it could have been that I stretched out in this delightful (oh yeah!) Florida sun and indulged myself in some unneeded sleep. Anyway, Bill, I have thought of you often and offer my sincere apologies and promise that I will do better by Little Bill in the future. I also enjoyed the reports from George Fletcher and Sam Albright. Hope we are the recipients of more of them in the future. I have received The Journal regularly and have read it from cover to cover each time it came. But I still reserve the "Random Thoughts" column for both first and last articles to be read.

Walter Easterling was here for quite a while but is now with the 239th Station Hospital, Fort Bragg, N. C., awaiting shipment overseas if he hasn't already been shipped. Ray Williams, Morrilton, was here for about a year but has recently been shipped overseas. These are the only native Arkansans we have had here but we have a goodly group of foreigners from Illinois, Ohio, Alabama and other places.

I have been here for the past twenty months except for eight weeks on D. S. in Washington last winter at the School of Tropical Medicine. Looks as if I'm destined to spend the remainder of my Army service with the AEF (American Exiles in Florida). I have been here so long that I have developed many of the native characteristics and could, I believe, qualify for a real Florida cracker if the inspection was not too rigid. Fact is, I have been here so long that when I walk down the streets of the nearby native village all the local crackers sitting in the shade in front of their buildings arouse themselves, slightly, from their naps, raise their eyes a little bit and drawl: "H'ya, Doc." I guess I've made good locally.

Really this isn't a bad place at all but I will still settle for my small portion of Arkansas and my friends there.

With best wishes to you and all my friends, I am

Very sincerely,

F. A. Corn, Major, M. C.,
Hendricks Field, Florida.

* Read before Annual Banquet Session, Sebastian County Medical Society, January 11, 1944.

COMMUNIQUE

February 5, 1944

To the Editor:

Enjoy the occasional letter full of information and approximate locations of a great many of my friends.

Fellow Arkansans are very rare here. Have seen only one medical officer from Arkansas in these parts since my arrival nineteen months ago. He was John Ruff, who only stayed a few weeks.

I am still fighting the battle of Camp Forest, Tennessee, but should get a change of scenery in the very near future. Probably a nice long trip to entirely new regions of the world. Will prove interesting to a country boy like me.

For the past eight months I have been in charge of the gastroenterology wards here at the hospital with a hand in the general medicine wards. Of course we get a variety of patients of all types and diseases. Is very interesting work at times but is monotonous.

Consider myself very lucky to have had my family with me for so long. We live in Winchester, Tennessee, which is a relatively nice town in a cut-throat sort of way.

Say hello to all my friends.

Sincerely,
H. H. Atkinson, Capt., M. C.
Station Hospital,
Camp Forest, Tennessee.

COMMUNIQUE

January 7, 1944

Dear Doctor Fletcher:*

I received the letter you wrote some time ago. It was most appreciated, I assure you. Would have answered sooner, but the holidays and all—. You are right, letters are certainly welcome, especially of things happening at home and about our friends and fellows there.

There are quite a few Arkansas Docs scattered along * * * *. We have been here almost two years and we'd like to see the old home state again. As a matter of fact, we may get that chance before too much longer, we hope.

A very nice officer's club was opened here Christmas Eve with a good party. We have good shows, movies and a few good USO troupes occasionally. It's really getting so civilized that we figure they must be going to name us. Our lives are probably less complicated than those of you fellows, with no taxes, rationing and red tape to

worry us. Seriously, I know that you fellows are doing a good job on the home front as well as backing us to the limit.

Those of us away from home are relying on you there to oppose state medicine, and to keep us informed of any developments or angles the bureaucrats might spring on us while we are temporarily disorganized. The thing we want most of all is to be able to return to the practice of medicine as we left it.

Again let me say, I heartily enjoyed hearing from you. Wish that a few more of the fellows would take just a few minutes to write us a note.

Best regards,
Lewis Hyatt, Capt., M. C.

* Reply to letter mailed to all members in service by Dr. Geo. B. Fletcher, Hot Springs National Park.

COMMUNIQUE

January 12, 1944

To the Editor:

Your thoughts of August caught up a short time back, also the "just this and that" of Pete Deisch—good old Pete, and just a few days ago the letter from Dr. Fletcher. It really is good to get such letters which, together with The Journal, give us news of the men at home as well as those scattered over the globe. Am getting The Journal quite regularly now. Had the pleasure recently of seeing John Samuel and entertaining him for a short time. Have just recently met a Fort Smith man, LaVasque is C. O. of one of the units assigned our organization. We will get better acquainted as time goes on. Wish you might see what war does to a country, the futility of it all! One's heart goes out to these homeless people, especially the poor, ragged, dirty children, who, God knows, had nothing to do with the destruction that has come to their homes. Happy New Year to all!

A. M. Washburn,
Lt. Col., M. C.

COMMUNIQUE

February 15, 1944.

To the Editor:

Thank you very much for sending the membership card and I am very sorry that you had to go to so much trouble. If I remember correctly I received the last year's card during the heat of

Doctor, *Write* this down in your Appointment Book *Now!*

- Date—Monday and Tuesday, April 17th and 18th
- Place—Wm. T. Stover Co.'s Exhibit, Marion Hotel, Little Rock, Arkansas
- Occasion—69th Annual Meeting Arkansas State Medical Society

Doctor, please accept our invitation to visit our four big booth displays, where welcome is written on our doormat and the latchstring hangs outside. See the latest in new equipment. Leave your coat, hat and packages, in fact, make it your headquarters.—See the new and latest Keleket. “**Complete**” Diagnostic X-Ray Unit at our X-Ray Booth.

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the Tunisian campaign while I was with the now famous First Infantry Division.

I was sent here as an instructor hoping that they might gain some benefit from my combat experience.

This is a wonderful training center for medical officers, medical soldiers and all medical department officers. At the present time we have over * * * young doctors here in training. If you are ever over this way it would be a real pleasure to show you around and I am sure you would enjoy seeing every bit of it.

I'll be tickled to receive The Journal again! I am hoping it won't be too long until some people call me "Doctor" again!

Faternally,
John T. Porter, Lt. Col., M. C.,
Training Division, M. R. T. C.,
Camp Barkley, Texas.

COMMUNIQUE

February 7, 1944.

To the Editor:

Want to thank you for sending The Journal on to me and call your attention to my recent change of address. I received letters from Drs. Fletcher and Allbright along with the Random Thoughts from you, all of which I enjoyed very much.

I had the good fortune to meet my good friend, Capt. Edwin Dunaway, of Conway, a few days ago. He is doing surgery in a near-by hospital which just opened recently. Sometime ago I met Lt. Stanley Cox who finished University of Arkansas Medical School. He told me that he was rooming with Tommy Foltz but I did not see Tommy as he was reassigned about that time.

No doubt you recently read in the home town paper about one William Stanton of your city who has many accomplishments to his credit. I am indeed proud of him along with the rest of my boys.

Will appreciate you sending The Journal to my new address.

Best personal regards,
Milton C. John, Jr., Capt., M. C.

WOMAN'S AUXILIARY NEWS

REPORT OF THE LEGISLATIVE COMMITTEE OF THE AUXILIARY TO THE ARKANSAS MEDICAL SOCIETY

In November, letters were sent to each county auxiliary asking that special programs be given to acquaint the public as well as the members with the true meaning of the Wagner-Murray-Dingell Bill S. 1161. Also over 2,000 folders were sent to the auxiliaries for distribution at meetings. These folders explained just how the \$3,048,000,-000.00 annually of extra taxes proposed in this bill would be used for political medicine.

Our doctors are busy with war-time practice; and our boys on the battlefield cannot fully realize the threat to the freedom of the American medical profession. It is up to us to do all we can to guide public opinion against a measure which if enacted would overthrow the entire structure of medical care in the United States.

If any auxiliary has not given this bill proper attention, please do so before it is too late.

Elizabeth M. Wolferman,
Chairman, Legislative Committee

The Auxiliary to the Pulaski County Medical Society met January 19th at the home of Mrs. Harry Hayes with a dessert luncheon. Mrs. A. R. Sparks, Mrs. Paul Autry, Mrs. H. M. Armstrong, were co-hostesses. Mrs. Randolph Smith, president, presided, and reports were heard from the committee chairmen. The sewing committee reported giving 226 hours and altering 396 garments for soldiers at Camp Robinson. Mrs. Paul Autry introduced Dr. L. L. Fatherree, city health officer, who spoke on the activities of the public health department. Mrs. Purifoy Gill, accompanied by Mrs. C. E. McSwain, gave three vocal numbers.

Mrs. H. A. Higgins,
Publicity Secretary

The December meeting of the Auxiliary to the Pulaski County Medical Society met with a one o'clock luncheon at the Woman's City Club with Mrs. C. P. Shukers and Mrs. Bryce Cummings as hostesses. Mrs. Paul Autry, program chairman, introduced Mrs. L. J. Kosminsky, State President, who spoke on the new developments in the field of medicine as a result of the war. The Choral Club from the high school sang several Christmas

carols. The wives of the army and navy doctors stationed in Little Rock were special guests.

Mrs. H. A. Higgins,
Publicity Secretary

Dear Auxiliary Members:

Our student loan fund is more or less at a stand still right now inasmuch as the government is paying the students such munificent wages that many more than usual are getting married. However, that is no reason for us to lose our enthusiasm and stop working. Now that so much money is in circulation is the very time to try to garner some of it for our fund, for there will be an aftermath and probably a greater need than ever for the extra dollars to tide the students over the emergencies of graduation, etc. Of the 71 loans we have made, all have been paid but eight. Of these, five of the debtors are in service, one is interning, one practicing, one in school. Two paid out after entering the service, but after they have gone across they have more urgent matters than paying off the few dollars they owe us.

So you may know how some of the boys feel about the loans, I am copying a letter recently received.

Camp.....
January 4, 1944

Dear Mrs. Oates:

You will note enclosed my money order in the amount of \$45.00. I think this will cover the balance on the principal and interest of my note to the Auxiliary. If it does not, please let me know. If it is in excess, will you please apply the excess to the credit of the student loan fund?

Let me again express my great appreciation to you and the other ladies of the Auxiliary for your kindness and generosity to me and to the many other students you have helped so greatly at times when the need for help was so acutely felt. I know of no time when the need for money is so pressing as during those last few weeks of the senior year when it seems that fees from this or that are coming from all sides and the middle.

Most sincerely yours,

....., Capt., M. C.

The loan fund has been credited with two dollars and sixty cents.

With best wishes for better things,

Ilse F. Oates,
Chairman of Committee



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BOOK REVIEWS

A Synopsis of Clinical Syphilis: By James Kirby Howles, B. S., M. D., Professor of Dermatology and Syphilology, and Director of the Department, Louisiana State University School of Medicine. 121 illustrations. Two color plates. Price \$6.00. Saint Louis: C. V. Mosby Company, 1943.

This text mainly concerns itself with the symptomatology of syphilis and pathology and treatment are presented according to the author's views. Excellent illustrations accompany the text. The subject is briefly but adequately presented.

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THE PROBLEM OF TUBERCULOSIS IN MENTAL HOSPITALS

A. C. KOLB, M. D.

Little Rock

The problem of tuberculosis in hospitals for mental diseases is common to all such institutions throughout the United States, as well as foreign countries. It exists in our own State Hospital.

The percentage of infection is high in all these institutions. Five per cent of all deaths from tuberculosis in the United States occur in hospitals for the mentally ill.

In the past, scant attention has been paid to this most serious problem of State Hospitals. Hidden tuberculosis, like the poisonous snake, disturbs no one until it is discovered. Until a few years ago, the average person considered it a disgrace to be infected with this disease. The present changed attitude on the part of the public has been brought about by improved methods of examination, whereby early diagnoses have been made thus aiding the recovery of the patient, and by educational programs by the Tuberculosis Associations in cooperation with the physicians over the country. All this has brought about a marked downward curve in the death rate of this disease during the past few years. This same situation applies to mental patients. The public regards the mental patient as hopeless. Relatives avoid discussions with reference to them. They are brought to the hospital for treatment only as a last resort and, as a result, many of them become chronic cases and spend the remainder of their lives in the institution. It is among this class that we find the highest percentage of tuberculosis.

In recent years, however, certain medical investigators have given the subject searching attention in some of the best institutions in this country. They have discovered certain facts which appear to be common to all of them: (1) The percentage of known cases in any institution will depend upon the intensity and accuracy of the case finding program. This involves both

equipment and highly trained medical personnel. (2) The percentage of patients infected with tuberculosis increases with the length of residence in the mental hospital. In the Hudson River State Hospital at Poughkeepsie, New York, it was found that the majority of patients diagnosed as tuberculous had been in the institution from five to fifteen years. This means that many contract the disease after admission. There can be but one reason for this: They became infected through contact with other patients already in the institution. Many mental patients have lowered resistance because they do not eat as they should. Many have delusions that poison is in their food, and they will not eat. Others suffer from certain mental diseases like dementia praecox, in which the symptom we call negativism is present. This is a symptom where the patient does the opposite to what a normal person would do, and refusal to eat is common. Many of these patients must be forced fed. This group comprises sixty per cent of the permanent patient population of all mental hospitals. The incidence of tuberculosis in this class is very high. (3) It is a known fact that many cases of tuberculosis among mental patients who already had the disease when admitted come from the low income group. We find this to be true in tuberculous patients where mental disease is absent. No doubt under-nutrition plays an important part in the production of the infection. (4) The majority of resident tuberculous patients is over 50 years of age and the percentage of tuberculosis increases with the length of residence.

Employees of mental hospitals who contract the disease usually do so after five years of service. Among the patients who already have the disease on admission are those cases who develop mental symptoms because of toxemia due to the tuberculous infection while under treatment in Tuberculosis Sanatoria and have to be transferred to a mental hospital. These, as a rule, are advanced bed cases and constitute our greatest hazard.

Any case finding program is fraught with many difficulties regardless of the method or instruments used, whether it be the fever ther-

mometer, stethoscope, X-ray, or skin test. The reason is obvious: The mental patient is not a cooperative one. To him the hospital is but a place of detention and rules and regulations mean nothing. Overcrowding is common to all mental institutions and, because of this, frequent transfers of patients from one medical service to another are necessary. This often results in failure of thorough examination.

Another difficulty in this work is the lack of medical personnel trained in the art of chest examinations. Psychiatrists, as a rule, are not efficient in this field and frequently fail to recognize early symptoms of the disease. Inadequate salaries for medical personnel prohibit the employment of specialists in chest work in mental hospitals. This is one of the most serious handicaps in any case finding and treatment program. There should be at least one physician well trained in the diagnosis and treatment of tuberculosis on the medical staff of every mental institution.

We have started a case finding program in our own State Hospital. During last December and January, every patient and employee of this institution was given an X-ray examination of the chest. 18 new cases of tuberculosis among patients and 5 cases among employees were discovered. We have now 150 known cases of tuberculosis.

Our facilities for the care and treatment of mentally ill tuberculosis patients are very poor. The white patients are hospitalized at the Benton Unit in frame buildings, which are inadequate. The colored tuberculosis patients are isolated on their respective wards here in the Little Rock Unit. This arrangement is far from being satisfactory. Treatment of these cases presents the same difficulties as those experienced in the diagnostic part of the program. Mentally normal patients in Sanatoria for the tuberculous cooperate in all phases of their treatment. They realize that the procedures of the Sanatorium, such as bed-rest, mental and physical relaxation, control of cough, and compliance with general routine of the institution are devised for their own welfare. The mentally ill tuberculous patients are non-cooperative. Many have to be tube fed. Others have to be restrained in bed and the problem of proper sanitary handling of sputum is always difficult. All this contributes to the hazard of spreading the disease to the uninfected. Also, when these patients recover from their mental illness, they should not be allowed to re-

turn to their homes to spread the disease to members of their family, and to others with whom they come in contact. This presents another unsolved problem.

The most serious problem in our State Hospital in the care and treatment of the tuberculous patients is the lack of a modern, properly designed infirmary, adequately equipped with up-to-date equipment and treatment rooms. Without this our efforts in this work will be futile.

Another serious problem which contributes to the increased percentage of cases in the State Hospital is that of overcrowding. This is common to all institutions throughout the country. At present there are 600 more patients in the Little Rock Unit than there is capacity. A new building with a capacity for 400 patients is now under construction here. This will relieve the situation to that extent. The 1943 Legislature appropriated \$200,000 for new buildings at Benton the board of control is anxious to begin this construction, but on account of restrictions on building materials this will be impossible until after the emergency. The public and the Legislature must fully realize that not much of a program of this nature can be carried out on the present appropriation of only 74c per day per patient, which includes food, clothing, medical treatment, salaries, and all other expenditures of the hospital. They must learn that mental patients are sick people like all other sick people and are entitled to a chance to get well, as those who are physically ill. No reasonable thinking person would for a moment consider 74c per day per patient in any other hospital in this state as anything like adequate in aiding such a one in recovery from his illness. Now add tuberculosis to an already mentally ill patient, and consider the problem on the basis of this meager allowance. This is the picture in our own State Hospital.

Success in any case finding and treatment program of the tuberculous mentally ill in this institution will depend upon adequate equipment, buildings especially designed for the care and treatment of these patients, and a trained medical personnel, to carry out the program. Overcrowded conditions must be relieved by the construction of other buildings for the non-infected group. All this will require the expenditure of considerable sums of money. Can our fair State afford to permit the present deplorable conditions to continue to exist, as they have in the past? All we need is the will and determination to do the job. IT CAN BE DONE.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

TO diagnose the greatest possible percentage of unsuspected cases of tuberculosis, to place these people under immediate and adequate care, to render them and the community safe from further spread of their disease, to rehabilitate every patient into a productive member of society—these are our tasks. Diagnostic procedures that guarantee the maximum return in case finding are those that safely apply the clinical lessons of the past to the pressing problems of the present. No thorough clinician relies exclusively upon a solitary diagnostic aid, even when circumstances strongly tempt him to do so.

TUBERCULIN TEST, X-RAY AND OTHER DIAGNOSTIC AIDS

There is now a strong tendency to "diagnose tuberculosis by short-cut and sometimes slipshod methods. Recently, a few physicians were asked how they would proceed to find all of the tuberculosis among the population of an entire industry or county. One stated that increased red cell sedimentation rate would ferret out all cases. Another would discover them by finding acid-fast bacilli in their sputa. Still another would employ only X-ray film inspection of their chests. Other similar methods were offered. Each physician presented an important phase of an examination, but not one of them was adequate. To achieve a satisfactory diagnosis each one of this group of physicians would have to examine a given individual in his own way, then pool his findings with those of his colleagues—a wasteful and illogical procedure.

There can be no tuberculosis in the absence of tubercle bacilli; therefore, the first phase of an examination is to determine whether bacilli are present. This can be done by the tuberculin test, which is accurate and specific except in the first few weeks after infection occurs, and in acutely ill and terminal cases. Other failures are usually due to the use of impotent tuberculin or to improper administration. Under proper conditions, then, a non-reactor to tuberculin can be told that he does not have living tubercle bacilli in his body. On the other hand, a reactor has at least primary lesions which contain living tubercle bacilli. Exceptionally, and only when all bacilli die, allergy persists for a time, then wanes and disappears. Inasmuch as primary tuberculosis is a prerequisite for the clinical forms, it is of extreme importance to know whether it is present. The

tuberculin test provides this information with uncanny accuracy. With the exceptions mentioned, it is with great rarity that the person with clinical tuberculosis fails to react to tuberculin.

The next phase of the examination consists of inspecting the chests of all adult reactors with the X-ray. On the ordinary film 25 per cent of the lung parenchyma is obstructed from view by shadows of such parts as the heart and diaphragm. Films fail to reveal evidence of primary tuberculosis in 70 to 80 per cent of the persons in whom it actually is present. So, too, may lesions of the reinfection type, because of their size and consistency, escape detection. It is a common experience to view a film which appears clear, yet one of the same chest a few months later reveals evidence of disease. Therefore, adult tuberculin reactors whose lungs appear normal should have films at least annually.

After tuberculous lesions of the reinfection type attain macroscopic (gross) proportions, X-ray inspection is by far our best method of detecting their locations when they are in that part of the lung which is visualized; indeed, they cast shadows on an average of two to three years before they cause significant symptoms. However, final diagnosis should never be made from X-ray shadows since those cast by tuberculous lesions may be indistinguishable from those of numerous other pulmonary diseases, such as sarcoidosis, silicosis, malignancy, fungus infections, abscess, and pneumonia. When a lesion is found, its etiology can usually be determined by other methods.

The present, widely used procedure which begins with X-ray inspection of the chests of large

groups of adults is laudable, provided it does not end there. All concerned must be informed that (1) X-ray inspection is done with the unaided eyes and reveals nothing but macroscopic (gross) lesions; (2) one-fourth of the lung parenchyma is obstructed from view by shadows of other parts; and (3) final diagnoses cannot be made with accuracy from X-ray shadows. Thus, the tuberculin test screens out those persons who have living tubercle bacilli in their bodies, and from them the X-ray screens out those who have gross lesions which may be tuberculous. Neither nor both procedures constitute an adequate examination.

To determine whether a demonstrable lesion is tuberculous one must seek tubercle bacilli in material obtained from it. Among individuals with extensive tuberculous lesions these are usually promptly recovered from the sputum. When bacilli are not found in more than one of several specimens, or if no sputum is present, gastric lavage may reveal their presence. Visualizing acid-fast organisms by the aid of the microscope may not be sufficient because of laboratory errors and also because nonpathogenic, acid-fast bacilli are sometimes found in the sputum and gastric contents; therefore, their pathogenicity should be determined by culture on artificial medium or by animal inoculation. In the event tubercle bacilli or other pathogenic organisms are not recovered, one should observe frequently new X-ray films to determine whether abnormal shadows persist or any significant changes occur in or around them. However, among persons beyond thirty-five years one should avoid delay, as the lesion may be malignant. In such cases the bronchoscopist should be consulted, as he may promptly reveal the etiology.

There is no more deplorable practice than to have tuberculin tests administered and X-ray films prepared, after which the physician makes diagnoses without seeing the subject and completing the examination. The individual should always be interviewed by the physician. While most persons have no symptoms for an average of two to three years after the disease can be located and practically none of those with primary tuberculosis give histories of significant illness, the tuberculin reactors whose chest films are entirely clear may relate symptoms caused by extra-thoracic tuberculosis. Indeed, they may be developing acute conditions, such as meningitis or military disease, or chronic lesions in such parts as the kidneys, pelvic organs, and bones and joints.

Following the interview, even though no significant evidence is obtained, the remainder of the traditional physical examination should be made, since significant pulmonary signs may be elicited from lesions located near the periphery or in parts of the lungs not visualized by X-ray; moreover, lesions may be found during the scrutiny of extra-thoracic regions.

To summarize: Tuberculosis begins when the first tubercle bacilli enter the human body and are focalized in microscopic lesions. At this stage the disease may lie dormant or may even disappear. Again, it may undergo exacerbations and remissions resulting in every form of clinical tuberculosis to which the human body is heir. The physician can now diagnose tuberculosis within a few weeks after the first invasion of tubercle bacilli, and he can detect most of the subsequent lesions with considerable promptness. Either to diagnose tuberculosis when it does not exist or to fail to find it when it is present, is inexcusable. Nearly all errors in diagnosis are due to short-cut or slipshod methods and may be avoided by employing every phase of a complete examination.

Tuberculin Test, X-ray and Other Diagnostic Aids, J. A. Myers, M. D., *Journal-Lancet*, April, 1944.

COMMUNIQUE

February 17, 1944

To the Editor:

Many thanks for the letter concerning the Arkansas physicians, also for the lovely poetry. I enjoyed reading both.

Have been in * * * several months and although I have run upon many medical officers I knew back in the States, so far I haven't met an Arkansas man. Hope to see some one from the old state soon.

We came over with our staff complete and, fortunately, have been permitted to remain intact. Have wonderful equipment to work with and although under tents, it isn't too bad. We can care for 400 to 600 patients comfortably, doing all surgery, including the specialties, that might be needed.

For your benefit am inclosing a couple of clippings from today's paper. Better watch out back there. It does not look good (socialized medicine) here.

Regards to the boys back home.

Fraternally,

H. K. Carrington, Capt., M. C.

THE JOURNAL

OF THE
ARKANSAS MEDICAL SOCIETY

Owned by the Arkansas Medical Society and Published
under direction of the Council

W. R. BROOKSHER, M. D., Editor
610 First National Bank Bldg. Fort Smith, Arkansas

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NEWS—Our readers are requested to send in items of news,
also marked copies of newspapers containing matter of interest
to the membership.

OFFICERS OF THE ARKANSAS MEDICAL SOCIETY

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COUNCILORS

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Eighth District—M. J. KILBURY	Little Rock
Ninth District—J. G. GLADDEN	Harrison
Tenth District—CLYDE McNEIL	Rogers

EDITORIAL

THE ANNUAL SESSION

The 69th Annual Session of the Arkansas Medical Society will be held at the Marion Hotel, Little Rock, April 17th-18th, repeating the successful two-day session inaugurated in 1943. The 1944 meeting promises to be the equal of any previous session. All commercial exhibit space is contracted for, a number of scientific exhibits have been arranged and the scientific program is an excellent one. Guest speakers will be R. M. Penick, Jr., Donovan C. Browne, and Neal Owens, all of New Orleans. A public meeting will not be held this year and on Monday evening, the Pulaski County Medical Society will entertain the members with a buffet dinner and dance. Business of great importance is scheduled for presentation to the House of Delegates. Each member is urged to be in attendance for the pleasures and profits of the annual session.

EDITORIAL COMMENT

MAKE HOTEL RESERVATIONS

Members planning to attend the annual session of the Society in Little Rock April 17th-18th, are

urged to make advance hotel reservations. Under present conditions hotel rooms in Little Rock are greatly in demand and those without advance reservations may find difficulty in securing accommodations. The Marion Hotel will make special effort to take care of those of our members who plan to attend the meeting if request is made in advance for rooms.

ADDRESSES WANTED

The Journal again appeals for addresses of the following members in military service. If you can supply the correct address, or if you can suggest someone who can, The Journal will appreciate the information.

J. F. Jackson, Walnut Ridge
John W. Dorman, Dyess
Vann C. Binns, Monticello
R. E. Smallwood, Hot Springs
T. L. Adair, Bald Knob
Glenn G. Hairston, Prescott
H. D. Fowler, Little Rock
John P. Eatton, Little Rock
Vincent M. Cox, Huttig
J. M. Sheppard, El Dorado

COMING MEDICAL MEETINGS

Regional Session, American College of Surgeons, Tulsa, Oklahoma, April 4th.

Arkansas Medical Society, Little Rock, April 17th-18th.

American Medical Association, Chicago, June 12th-16th.

COMMUNIQUE

February 28, 1944

To the Editor:

Your last "letter" was read and very much appreciated, having been forwarded to me. Am somewhere in * * *, not too far from the Nips (the so- and so-s), and am learning what the preservation of life in the jungle means. When I used to read that it took days to capture a small hill, I used to wonder. News reels of the jungle showed occasional paths, but, brother, until you've seen how hard it is to get through jungle, it's hard to appreciate. Best regards to all our friends and acquaintances.

Yours,

John J. Monfort, Capt., M. C.

Preliminary Program and Announcements

OF THE

SIXTY-NINTH ANNUAL SESSION OF THE

ARKANSAS MEDICAL SOCIETY

LITTLE ROCK

APRIL 17, 18, 1944

HEADQUARTERS—MARION HOTEL

OFFICERS

S. J. Albright, President, Searcy
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 B. L. Moore, Third Vice-President, El Dorado
 Paul L. Mahoney, Treasurer, Little Rock
 W. R. Brooksher, Secretary, Fort Smith
 Hon. Peter A. Deisch, Counsel, Helena

COUNCILORS AND COUNCILOR DISTRICTS

Clyde McNeil, Chairman, Rogers

First District—Clay, Crittenden, Craighead, Greene, Lawrence, Mississippi, Poinsett and Randolph counties. P. W. Lutterloh, Jonesboro. Term of office expires 1943.

Second District—Clebune, Fulton, Independence, Izard, Jackson, Sharp, Stone and White counties. L. T. Evans, Batesville. Term of office expires 1944.

Third District—Arkansas, Cross, Lee, Monroe, Phillips, Prairie, Saint Francis and Woodruff counties. J. O. Rush, Forrest City. Term of office expires 1943.

Fourth District—Ashley, Bradley, Chicot, Cleveland, Desha, Drew, Jefferson and Lincoln counties. S. W. Douglas, Eudora. Term of office expires 1944.

Fifth District—Calhoun, Columbia, Dallas, Lafayette, Ouachita and Union counties. S. A. Thompson, Camden. Term of office expires 1943.

Sixth District—Hempstead, Howard, Little River, Miller, Nevada, Pike, Polk and Sevier counties. C. E. Kitchens, DeQueen. Term of office expires 1944.

Seventh District—Clark, Garland, Hot Spring, Montgomery and Saline counties. H. King Wade, Hot Springs National Park. Term of office expires 1943.

Eighth District—Conway, Faulkner, Grant, Lonoke, Perry, Pope, Pulaski, Van Buren and Yell counties. M. J. Kilbury, Little Rock. Term of office expires 1944.

Ninth District—Baxter, Boone, Carroll, Marion, Newton and Searcy counties. J. G. Gladden, Harrison. Term of office expires 1943.

Tenth District—Benton, Crawford, Franklin, Johnson, Logan, Madison, Sebastian, Scott and Washington counties. Clyde McNeil, Rogers. Term of office expires 1944.

EX-OFFICIO COUNCILORS

S. J. Albright, President, Searcy
 Jos. F. Shuffield, President-Elect, Little Rock
 Paul L. Mahoney, Treasurer, Little Rock
 W. R. Brooksher, Secretary, Fort Smith

STANDING COMMITTEES

(Appointments expire with the annual session of the year indicated.)

SCIENTIFIC WORK—M. C. Hawkins, Jr., Searcy, Chairman (1946); H. King Wade, Hot Springs National Park (1944); *Joe H. Sanderlin, Little Rock, (1945); W. R. Brooksher, Fort Smith (ex-officio).

MEDICAL LEGISLATION—Jos. F. Shuffield, Little Rock, Chairman (1946); S. J. Wolferman, Fort Smith (1944); M. L. Norwood, Lockesburg (1944); W. G. Hodges, Malvern (1945); Earle H. Hunt, Clarksville (1946).

MEDICAL EDUCATION AND HOSPITALS—A. J. Dunklin, Searcy, Chairman (1946); M. J. Kilbury, Little Rock (1944); O. W. Clark, Pine Bluff (1944); Earle H. Hunt, Clarksville (1945).

HEALTH AND PUBLIC INSTRUCTION—W. B. Grayson, Little Rock, Chairman (1946); Byron L. Robinson, Little Rock (1945); J. Harry Hayes, Little Rock (1945); R. M. Eubanks, Little Rock (1944); Hoyt R. Allen, Little Rock (1944).

PUBLIC RELATIONS—W. T. Wootton, Hot Springs National Park, Chairman (1945); *J. M. Kolb, Clarksville (1945); S. W. Douglas, Eudora (1946).

MEDICAL ECONOMICS—H. E. Mobley, Morrilton, Chairman (1945); Thos. Wilson, Wynne (1944); R. M. Blakely, Little Rock (1945).

SCIENTIFIC EXHIBIT—M. J. Kilbury, Little Rock, Chairman (1945); *A. G. Sullivan, Hot Springs National Park (1944); W. C. Langston, Little Rock (1944); W. Decker Smith, Texarkana (1944); Geo. C. Burton, Bald Knob (1946).

NECROLOGY—Bert L. Ware, Fort Smith, Chairman (1946); O. J. T. Johnson, Batesville (1945); C. A. Archer, DeQueen, (1945); E. F. Ellis, Fayetteville, (1944); W. H. Mock, Prairie Grove (1944); W. W. Verser, Harrisburg (1946).

CANCER CONTROL—Fred Hames, Pine Bluff, Chairman (1945); Glenn Johnson, Little Rock (1944); D. E. White, El Dorado (1945); S. A. Drennen, Stuttgart (1946); C. S. Means, Fort Smith (1946).

SPECIAL COMMITTEES

MATERNAL AND CHILD WELFARE—S. A. Thompson, Camden, Chairman; Don Smith, Hope; Robt. Hood, Russellville; E. C. McMullen, Pine Bluff; J. G. Gladden, Harrison; D. W. Sloan, Beebe.

HEART—J. N. Compton, Little Rock, Chairman; A. A. Gilbert, Fayetteville; O. C. Melson, Little Rock.

CONTROL OF SYPHILIS—Louie G. Martin, Hot Springs National Park, Chairman; D. W. Goldstein, Fort Smith; E. I. Thompson, Little Rock; E. L. Watson, Newport.

POSTGRADUATE STUDY—D. A. Rhinehart, Little Rock, Chairman; J. S. Wilson, Monticello; Chas. S. Holt, Fort Smith; L. T. Evans, Batesville; †E. H. Bing, Marshall; A. S. Buchanan, Prescott; H. A. Stroud, Jonesboro; J. B. Jameson, Camden; C. E. Dungan, Augusta; J. P. Bremer, Point Cedar.

AUXILIARY—L. J. Kosminsky, Texarkana, Chairman; O. J. T. Johnston, Batesville; E. D. McKnight, Brinkley; J. K. Walker, Pine Bluff; H. T. Smith, McGehee.

STUDY OF MIDWIFERY—J. B. Jameson, Camden, Chairman; Roy I. Millard, Russellville; T. G. Porter, Hazen; J. H. McCurry, Cash.

LIAISON WITH ARKANSAS TUBERCULOSIS ASSOCIATION—A. C. Shipp, Little Rock, Chairman; E. A. Callahan, Carlisle; S. C. Fulmer, Little Rock; J. D. Riley, State Sanatorium; W. H. Bruce, Pine Bluff; B. C. Middleton, Texarkana.

INDUSTRIAL HEALTH—E. E. Barlow, Dermott, Chairman; S. A. Drennen, Stuttgart; Fred W. Harris, Little Rock; M. E. Foster, Fort Smith; W. J. Hunt, Warren.

MENTAL HYGIENE—N. T. Hollis, Little Rock, Chairman; Geo. B. Fletcher, Hot Springs National Park; A. C. Kolb, Little Rock; Elizabeth Fletcher, Little Rock; Pat Murphey, Little Rock.

ADVISORY TO STATE INSTITUTIONS—R. B. Robins, Camden, Chairman; Geo. B. Fletcher, Hot Springs National Park; Robert Caldwell, Little Rock; Clyde McNeil, Rogers; W. R. Brooksher, Fort Smith.

COMMITTEE ON MEDICAL SERVICE AND PUBLIC RELATIONS—P. W. Lutterloh, Jonesboro, Chairman; A. S. Buchanan, Prescott; Alan G. Cazort, Little Rock; J. S. Wilson, Monticello; S. D. Kirkland, Van Buren.

* In Military Service
† Deceased

LOCAL COMMITTEES

Host County Society—Pulaski County Medical Society.

GENERAL CHAIRMAN—Bryce Cummins.

RECEPTION—D. A. Rhinehart, Chairman; A. C. Shipp, H. Fay H. Jones, Paul L. Mahoney.

ARRANGEMENTS—Bryce Cummins, Chairman; H. S. Stern, Hoyt R. Allen.

PUBLICITY—Allen G. Cazort, Chairman.

ENTERTAINMENT—R. T. Smith, Chairman; C. R. Henry, W. J. Schwarz.

SCIENTIFIC EXHIBITS—Paul L. Day, Chairman; R. H. Rigdon, K. W. Cosgrove, P. C. Eschweiler.

COMMERCIAL EXHIBITS—Jos. F. Shuffield, Chairman; Hoyt R. Allen.

ANNOUNCEMENTS

REGISTRATION

The registration desk will be located in the Marion Hotel and will be open from 8:00 A. M. to 5:00 P. M. Monday, April 17; from 8:00 A. M. to 2:00 P. M., Tuesday, April 18th and from 3:00 P. M. to 5:00 P. M., Sunday, April 16th. Members of the Pulaski County Medical Society are requested to register on Sunday afternoon, April 16th, to avoid congestion after opening of the session. Delegates are requested to register as early as possible, presenting credentials at the time of registra-

tion. Members and visitors are requested to register and receive the official badge and program. Admission to all sessions will be by badge. Bring your 1943 registration card to facilitate registration. Members of the American Medical Association from any state may register as guests.

MEETINGS OF THE COUNCIL

The Council of the Arkansas Medical Society, including the Past-Presidents, will meet at noon, April 17th and 18th, in Parlor "A," Marion Hotel, immediately following the adjournment of the morning session.

PAST-PRESIDENT'S BREAKFAST

The Past-Presidents of the Society will convene in their annual breakfast session Tuesday, April 18th, in Parlor "A," Marion Hotel, at 7:30 A. M.

PROGRAM

HOUSE OF DELEGATES

First Meeting Marion Hotel

Monday, April 17th, 9:00 A.M.

President S. J. Allbright, Presiding

Calling meeting to order.

Roll call of delegates.

Report of Credentials Committee.

Introduction of Fraternal Delegates.

Adoption of Minutes of the Sixty-eighth Annual Session, published in the June, 1943, issue of The Journal of the Arkansas Medical Society.

Appointment of Reference Committee.

President's Address to the House of Delegates.

REPORT OF COMMITTEES

(Limited to ten minutes by House of Delegates;
1942 session)

ARRANGEMENTS—Bryce Cummins, Chairman.

SCIENTIFIC WORK—M. C. Hawkins, Chairman.

MEDICAL LEGISLATION—Jos. F. Shuffield, Chairman.

HEALTH AND PUBLIC INSTRUCTION—W. B. Grayson, Chairman.

MEDICAL EDUCATION AND HOSPITALS—A. J. Dunklin, Chairman.

PUBLIC RELATIONS—W. T. Wootton, Chairman.

MEDICAL ECONOMICS—H. E. Mobley, Chairman.

SCIENTIFIC EXHIBIT—M. J. Kilbury, Chairman.

NECROLOGY—B. L. Ware, Chairman.

CANCER CONTROL—Fred Hames, Chairman.

HEART—J. N. Compton, Chairman.

STUDY OF MIDWIFERY—J. B. Jameson, Chairman.

MATERNAL AND CHILD WELFARE—S. A. Thompson, Chairman.

POSTGRADUATE STUDY—D. A. Rhinehart, Chairman.

AUXILIARY—L. J. Kosminsky, Chairman.

CONTROL OF SYPHILIS—Louie G. Martin, Chairman.

LIAISON WITH ARKANSAS TUBERCULOSIS ASSOCIATION—A. C. Shipp, Chairman.

INDUSTRIAL HEALTH—E. E. Barlow, Chairman.

MENTAL HYGIENE—N. T. Hollis, Chairman.

COMMITTEE ON MEDICAL SERVICE AND AND PUBLIC RELATIONS—P. W. Lutterloh, Chairman.

ADVISORY COMMITTEE TO STATE INSTITUTIONS—R. B. Robins, Chairman.

REPORT OF THE STATE MEDICAL BOARD OF THE ARKANSAS MEDICAL SOCIETY—D. L. Owens, Secretary.

REPORT OF THE DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION—E. E. Barlow, Dermott.
 REPORT OF THE COUNCIL—Clyde McNeil, Chairman.
 REPORT OF THE TREASURER—Paul L. Mahoney, Little Rock.
 REPORT OF THE SECRETARY—W. R. Brooksher, Fort Smith.
 REPORT OF COUNSEL—Hon. Peter A. Deisch, Helena.
 REPORT OF FRATERNAL DELEGATES.
 NEW BUSINESS.

The following amendments, presented to the 1943 session of the House of Delegates and published twice in The Journal of the Arkansas Medical Society, are before the House of Delegates for final action.

Proposed amendment to the By-Laws of the Constitution of the Arkansas Medical Society as follows:

Chapter V. Section 1.

To amend the fifth sentence which now reads:

"The committee shall report the result of its deliberations to the House of Delegates in the shape of a ticket containing the names of the three members for the office of President-Elect and of one member for each of the other offices to be filled at the Annual Session."

To read:

"The committee shall report the result of its deliberations to the House of Delegates in the shape of a ticket containing the names of two or more members for the office of President-Elect and of one member for each of the other offices to be filled at the Annual Session."

Proposed amendment to the By-Laws of the Constitution of the Arkansas Medical Society:

To amend the first sentence of Section 2, Chapter VI of the By-Laws which now reads:

"The President-Elect shall be a member ex-officio of the Council and the House of Delegates without the power of voting."

To read:

"The President-Elect shall be a member of the Council and the House of Delegates."

This is to conform with a previous amendment of the Constitution adopted last year which made the same change in Article VI of the Constitution.

SELECTION OF THE NOMINATING COMMITTEE.

SCIENTIFIC SESSION

MONDAY AFTERNOON, APRIL 17th, 1:30 P.M.

PRESIDING, S. J. Allbright, President.
 INVOCATION—The Rt. Rev. Msgr. John J. Healey, Director of Catholic Hospitals, Diocese of Little Rock.
 ADDRESS OF WELCOME—Carl A. Rosenbaum, President, Pulaski County Medical Society.
 RESPONSE FOR THE ARKANSAS MEDICAL SOCIETY—J. S. Wilson, Monticello.
 PRESIDENT'S ADDRESS—S. J. Allbright, Searcy.
 "Surgical Management of Hernias"—H. E. Mobley, Morrilton.
 "The Application of Fundamental Principles in the Treatment of Burns"—Neal Owens, New Orleans.
 "Caudal Anesthesia"—I. F. Jones, Fort Smith.
 "Cardiospasm: Its Medical Management"—Donovan C. Browne, New Orleans.
 "Newer Methods of Treating the Mentally Ill"—N. T. Hollis, Little Rock.

MONDAY EVENING, APRIL 17th, 6:30 P.M.

Marion Hotel Ballroom

The Pulaski County Medical Society will entertain with a buffet dinner, reception and dance honoring the members and visitors.

SCIENTIFIC SESSION

TUESDAY MORNING, APRIL 18th, 9:00 A.M.

PRESIDING—S. J. Allbright, President.
 "Tuberculosis Control Program in Arkansas"—A. C. Curtis, Little Rock.
 "The Diagnosis and Treatment of Various Arterial Aneurysms"—R. M. Penick, Jr., New Orleans.
 "Tumor Clinic of the University of Arkansas School of Medicine"—Carl A. Rosenbaum, Little Rock.
 "A Brief Summary of the Modern Concepts of Acquired Syphilis"—E. J. Easley, Little Rock.
 "How to Differentiate Emotional Glycosuria from Diabetes Mellitus"—L. N. Bollmeier, Hot Springs National Park.

MEMORIAL SESSION

TUESDAY, APRIL 18th, 11:30 A.M.

PRESIDING—S. J. Allbright, President.
 INVOCATION—Rev. S. F. Bryant, Pulaski Heights Presbyterian Church.
 DUET—"God Shall Wipe Away All Tears"—Cara Roma, Mrs. Henry Franklin; Mrs. E. Charles Eichenbaum.
 READING THE NAMES OF DECEASED MEMBERS OF THE AUXILIARY—Mrs. H. T. Smith, McGehee.
 ADDRESS—B. L. Ware, Greenwood, Chairman, Committee on Necrology.
 SOLO—"The Lord's Prayer"—Mallotte, M. George Jernigan.
 BENEDICTION—Rev. S. F. Bryant, Pulaski Heights Presbyterian Church.

IN MEMORIAM

Lyle Gordon Young, Van Buren, April 19, 1943.
 Leonard R. Ellis, Hot Springs, May 10, 1943.
 William Jefferson Hutson, Eudora, June 20, 1943.
 Meade B. Owens, Newport, June 20, 1943.
 Tilden Paul Fowler, Harrison, July 5, 1943.
 James Silas Kolb, Clarksville, August 9, 1943.
 Cheves Beville, Waldron, August 28, 1943.
 Noble Jackson Hill, Hindsville, September 1, 1943.
 John A. Moore, El Dorado, September 9, 1943.
 Edward Rush King, Ashdown, September 24, 1943.
 George Kellogg Stephens, Newport, October 5, 1943.
 Moses Green Daly, Little Rock, December 12, 1943.
 Elbert Amsden Bing, Marshall, February 2, 1944.
 Columbus Edgar Gannaway, Warren, March 5, 1944.
 James Henderson Fowler, Harrison, March 10, 1944.

HOUSE OF DELEGATES

FINAL SESSION

TUESDAY, APRIL 18th, 1:30 P.M.

CALLING THE MEETING TO ORDER—S. J. Allbright, President.
 ROLL CALL
 REPORT OF THE NOMINATING COMMITTEE

ELECTION OF OFFICERS

- President-Elect
- First Vice-President
- Second Vice-President
- Third Vice-President
- Treasurer
- Secretary
- Five Councilors
- Delegate to the American Medical Association
- Alternate to the American Medical Association

REPORT OF THE REFERENCE COMMITTEE

REPORT OF COMMITTEES

NEW BUSINESS

ADJOURNMENT

FINAL GENERAL SESSION

TUESDAY, APRIL 18th

(Immediately following the adjournment of the Final Session of the House of Delegates)

- CALLING THE MEETING TO ORDER—S. J. Albright, President.
- UNFINISHED BUSINESS
- PRESENTATION OF PRESIDENT JOS. F. SHUFFIELD
- PRESENTATION OF PRESIDENT-ELECT
- NEW BUSINESS
- SELECTION OF PLACE OF NEXT MEETING
- ADJOURNMENT SINE DIE

SCIENTIFIC EXHIBIT

- Baptist State Hospital, Department of Pathology, Little Rock—"A Comparison of Periarthritis Nodosa with a Hypertensive Vascular Reaction Probably Due to Sulfonamide Therapy."
- School of Medicine, University of Arkansas, Little Rock—1. "The Medical School in Wartime"—Office of the Dean.
- 2. "Newer Methods of Treating the Mentally Ill"—Department of Psychiatry.
- 3. "State Blood Plasma Program."
- 4. "Clinical and Experimental Observations on the Effect of Hypertonic Sucrose on the Kidney."—Department of Pathology.
- 5. "An Experimental Decompression Chamber"—Department of Physiology and Pharmacology.
- Arkansas Association of Medical Technologists—"A Tribute to Experimental Animals."
- "Neuro-pathological Specimens"—Robert Watson, Little Rock.

COMMUNIQUE

March 4, 1944

To the Editor:

I am enclosing a check for \$7.50 subscription to "Random Thoughts." I still say, in spite of your threats, that this is high price to pay for such thoughts.

S. P. McConnell.

FOR SALE—Complete office equipment for physician including walnut suite and diathermy apparatus, all in excellent condition. Write Mrs. E. A. Bing, Marshall, Arkansas.

RANDOM THOUGHTS OF THE SECRETARY

February 25th. Enjoying the majestic Ouachita Mountains from U. S. 71, where views compare favorably with those in the Rockies or Blue Ridges, and are seen with fresh beauty this morning because of our enforced absence of over two years in driving this highway. At DeQueen we work with Ewell Thompson in the diagnostic clinic where many folks evidence an interest to know if they have cancer, as do twenty-five per cent of those in attendance.

March 1st. This day conferring with Selective Service over various matters in connection with the further functions of procurement and assignment and then with the Pülaski County local committee in discussion over plans for the coming annual session. This time Bryce Cummings is of the same opinion before and after the luncheon regarding the social affairs of the meeting, a contrast with his ideas on the same subject last year. Calling on Grayson, finding him out of his office, and thus we are able to repay remarks of his concerning absences of ours from the office. Returning home to find that Shippey was in our office during our absence and we are sorry we missed hearing his tales of the Far East.

March 1st. Today we pay the income tax people and because we know Jim Amis worries about his next paycheck, we have dedicated this payment for that special purpose.

March 4th. Comes the news that after 35 years of service as county society secretary, J. H. McLean, Caddo Gap, has been promoted to president.

March 9th. Visiting Camp Gruber this afternoon as guests of Col. Price of the old 142nd, and privileged to see many of the inner workings of the army so far denied us while the youngster takes to M-10s and jeeps in great glee. Comes retreat and we are prone to sermonize over the sight of the captive Herrenvolk marching across the tracks and highways to their camp, to them the war is history; on this side, the eager 42nd Division impatiently waits its opportunity to become an active part of the conflict.

March 10th. Comes Shippey with many a tale of overseas and especially of Hindu customs and we gather from his conversation that his acquaintance with the native language is restricted to "Burrowpeg, sahib!" which will at least mean something to our readers in the C. B. I. theater, who, incidentally, have the swellest shoulder insigne we have yet seen.

March 14th. For the second time, Art Martin passes through Fort Smith on orders and finds us elsewhere engaged.

March 15th. Busily engaged at Jonesboro with fellow clinician, Ewell Thompson, having opportunity for greetings with Modelevsky, Horner and Ledbetter, for lunch with Lutterloh and for heckling with radiologist Willett. In due course seeing the last of the patients and back toward Little Rock, guests of the Ewell Thompsons, stopping at Searcy's Mayfair where Dunklin reports late for the evening meal, somewhat unusual we would say. Then, time marching rapidly, we bring some of the hectic moments of our family life into the life of the Ewell Thompsons, as haste is made to catch the Rocket, an accomplishment we feel all despaired of save us.

March 16th. For the first time since April, 1941, we meet a soldier wearing the regimental insignia of the 206th C A (A-a) and we are glad with them that an enforced foreign stay is completed.

PROCEEDINGS OF SOCIETIES

The Miller-Bowie Counties Medical Society was addressed March 24th by P. S. Pelouze, on "Gonorrhea."

Geo. W. Parson, Secretary.

Clark County Medical Society has elected the following officers: President, C. K. Townsend; Secretary-treasurer, Joe W. Reid; Delegate, C. K. Townsend; and Alternate, Joe W. Reid.

Woodruff County Medical Society has elected the following officers: President, J. W. Morris, McCrory; Vice-president, F. C. Maguire, Augusta; Secretary-treasurer, C. E. Dungan, Augusta; Delegate, C. E. Dungan, and Alternate, F. C. Maguire.

Carroll County Medical Society has elected the following officers: President, A. L. Carter, Berryville; Vice-president, J. F. John, Eureka Springs; Secretary-treasurer, D. K. McCurry, Green Forest; Delegate, J. F. John, and Alternate, D. K. McCurry.

Lafayette County Medical Society has elected the following officers: President, F. E. Baker, Stamps; Vice-president, Secretary-treasurer, A. W. Keith, Stamps; Delegate, R. L. Armstrong, Lewisville, and Alternate, J. F. McKnight, Bradley.

The Benton County Medical Society met in dinner session at Springdale March 16th for an address on "Gonorrhea" by Percy S. Pelouze.

Geo. M. Love, Secretary.

Desha County Medical Society has elected the following officers: President, H. A. Rands, Dumas; Secretary-treasurer, Gibbs Biscoe, Dumas; Delegate, H. T. Smith, McGehee, and Alternate, H. A. Rands.

The Miller-Bowie Counties Medical Society was addressed March 17th by P. G. Gilmer, Shreveport, on "Special Diagnostic Procedures in Diseases of the Chest."

Geo. W. Parson, Secretary.

The Lawrence County Medical Society was addressed at its March meeting by J. H. McCurry, Cash, and Capt. Kahan, M. C., Walnut Ridge Air Base:

Chas. D. Tibbels, Secretary.

Phillips County Medical Society met in its 73rd annual session February 7th electing the following officers: President, W. C. King; Vice-president, J. W. Nicholls, and Secretary-treasurer, M. Fink.

The Craighead-Poinsett County Medical Society met March 2nd with A. C. Modelvesky reading a paper on pediatrics and Mr. H. Z. Baker presenting a program of magic and mystery. The following were elected delegates; J. H. McCurry, Cash and L. H. McDaniel, Tyronza, and alternates, W. C. Overstreet, Jonesboro, and J. K. Jones, Lepanto.

Monroe County Medical Society has elected the following officers: President, M. L. Dalton, Brinkley; Vice-president, W. H. Martin, Holly Grove; Secretary-treasurer, W. L. Boswell, Clarendon; Delegate, E. D. McKnight, Brinkley, and Alternate, W. T. Bradley, Blackton.

Mississippi County Medical Society has elected the following officers: President, T. F. Hudson, Luxora; Vice-president, E. C. Budd, Blytheville; Secretary-treasurer, P. W. Turrentine, Osceola; Delegate, L. L. Hubener, Blytheville, and Alternate, W. J. Shedd, Osceola.

The Pulaski County Medical Society was addressed March 20th by Percy S. Pelouze on the treatment of gonorrhea.

Elizabeth D. Fletcher, Secretary.

Montgomery County Medical Society has elected the following officers: President, J. H. McLean, Caddo Gap; Secretary-treasurer, G. E. Watkins, Mount Ida; Delegate, J. H. McLean, and Alternate, W. D. Freeman, Mount Ida.

Lawrence County Medical Society has elected the following officers: President, J. L. Merrell, Walnut Ridge; Vice-president, R. S. Faircloth, Walnut Ridge; Secretary-treasurer, Chas. D. Tibbels, Black Rock. Delegate, J. C. Land, Walnut Ridge, and Alternate, H. B. Hull, Mammoth Spring.

Union County Medical Society has elected the following officers: President, B. L. Moore; Vice-president, E. J. Munn, and Secretary-treasurer, M. V. Russell, all of El Dorado.

PERSONALS AND NEWS ITEMS

Lt. Jack A. King, Elaine, is now stationed overseas.

Woodrow E. Phipps, North Little Rock, has been appointed Lieutenant, Medical Corps, Army of the United States, and ordered to active duty.

Capt. Julius K. Sheppard, El Dorado, is now stationed at Station Hospital, Camp Roberts, California.

H. A. Rands, Dumas, recently took a two weeks' course in obstetrics at Cook County Graduate School of Medicine in Chicago.

Among those in attendance at the New Orleans Graduate Medical Assembly were C. A. Archer, DeQueen, Virgil Payne, Pine Bluff, and E. I. Thompson and M. J. Kilbury, Little Rock.

Capt. John B. Elders, Walnut Ridge, has been transferred to Camp Bowie, Texas.

Ewell I. Thompson, Little Rock, and W. R. Brooksher, Fort Smith, conducted a diagnostic cancer clinic at Jonesboro March 15th under the auspices of the Craighead-Poinsett County Medical Society and the Women's Field Army.

Roy T. Goodwin, formerly with Maumelle Ordnance Works, Little Rock, is now medical director at Brown Shipbuilding Corporation, Houston, Texas.

L. S. Dunaway has been discharged from the army medical corps and has returned to practice in Conway.

J. K. Grace, Belleville, now stationed at Tampa, Florida, has been promoted to lieutenant-colonel.

R. M. Blakely has been elected a school director at Little Rock.

John W. Dorman, Dyess, has been promoted to lieutenant-colonel.

Dr. and Mrs. E. F. Brewer, Augusta, celebrated their golden wedding anniversary March 22nd.

James G. Martindale, Hope, now stationed at Dyersburg, Tennessee, has been promoted to major.

Lt. L. T. Taylor, Star City, has been transferred to Naval Air Station, Pensacola, Florida.

J. L. Pickens, Bentonville, now stationed with the army air forces at Altus, Oklahoma, has been promoted to captain.

J. Harry Hayes, Little Rock, has been elected a Fellow of the International College of Surgeons.

Gilbert Alexander has been transferred from Fayetteville to the Veterans Administration Facility, Muskogee, Oklahoma.

Ewell I. Thompson, Little Rock, and W. R. Brooksher, Fort Smith, conducted a diagnostic cancer clinic at DeQueen February 25th under the auspices of the Sevier County Medical Society and the Women's Field Army.

Barney P. Briggs, Little Rock, now stationed at Shepherd Field, Texas, has been promoted to major.

Lt. Col. W. W. Chamberlain, Hot Springs National Park, has been transferred to Regional Hospital, Barksdale Field, Louisiana.

George F. Stocker, Fort Smith, now on duty in the South Pacific, has been commissioned in the naval medical corps as lieutenant.

R. B. Robins, Camden, recently addressed the Arkadelphia Lions Club and the Hot Springs Kiwanis Club.

Leslie Gordon Holt, Little Rock, has been called to duty as Lieutenant, Medical Corps, Army of the United States, and assigned to Carlisle Barracks.

Capt. Thos. J. Raney, Little Rock, has been transferred to Station Hospital, Camp Hood, Texas, after a long period of service in the Aleutians.

Capt. E. B. Burt, Crossett, is now stationed at Station Hospital, Fort Omaha, after completing a course in military neuropsychiatry at the Mason General Hospital.

Capt. H. K. Carrington, Magnolia, is now on duty overseas with an evacuation hospital.

Capt. Vincent O. Lesh, Fayetteville, is now on duty overseas with a station hospital.

L. R. Boen, Oakgrove, has moved to Bauxite.

Capt. W. A. Regnier, Crossett, is now stationed overseas.

Paul C. Eschweiler addressed the Little Rock Civitan Club March 1st on the University of Arkansas School of Medicine Blood Bank.

Doris A. Baldridge, Conway, has moved to Vero Beach, Florida.

Fount Richardson, Fayetteville, now on duty overseas, has been promoted to lieutenant-colonel.

Carl L. Wilson, Fort Smith, now stationed at Camp Maxey, Texas, has been promoted to major.

Capt. Jack M. Sheppard, El Dorado, is now stationed overseas.

Capt. J. Donald Hayes, Little Rock, is now stationed at Station Hospital, Army Air Field, Laredo, Texas.

Capt. G. D. Murphy, Jr., El Dorado, is now stationed with the army air forces at Laurel, Mississippi.

Lt. Art B. Martin, Fort Smith, is now assigned to the School of Aviation Medicine, Randolph Field, Texas.

COMMUNIQUE

February 4th, 1944

To the Editor:

Just a line to inform you of my change of address. It finds me as assistant regimental surgeon. I was quite glad to move up to "City Hall" (Reg. Hq.) from the position of battalion surgeon where I was cheating a mule out of a job. It's no joke to march 22 miles with a heavy marching order. These field packs weigh about 20.5 pounds but after five miles, the decimal point drops out.

But, it's everything first class here at "City Hall." We even have running water in our tent. Perhaps I should say on our tent. We put out two large 55-gallon petrol drums at the lower corners of our tent. It's a rare night when we don't collect both drums full. It's been raining

in torrents now for days, but we're lucky until the monsoons start.

When it rains so much the sun is a curiosity. It is very hard to get our laundry dry. But come hell or high water, I'm going to wash this suit of dungarees next week for sure. The only convenience resulting from wearing the same clothes so long is that we can stand them up by our bunk. In case of an alert one can jump in them like a fireman and be away to a shelter with no lost motion. I used to worry about the tattle tale gray color of my clothes but my neighbor's look even worse so I don't have to hang them up at sundown anymore.

We have running water in our shower, too. There are a few holes punched in the bottom of a large can and the water runs very fast until you have to fill up the can again.

Before leaving the States (ages ago), I always wanted to see the exotic tropical isles. But, take it from an old salt this steaming, stinking jungle is so dense one takes a compass to find his way to the head. But the latrines are unique, just slam down the lid instead of flushing the modern type. Now if you remembered to bring a machette you can cut a trail back to your tent. The vines grow so fast that the one you came out on is grown over again. These little yellow men exploded that myth about the tropics for certain.

The chow is terrible. We're lucky though, we have those new type powdered eggs. The boys don't waste time cracking the shells on the old fashioned ones like the civilians do (or do they?). It was a dirty shame to shoot down that plane the other day especially after he had blown up all our bully beef.

Profanity in the service is just a convenience to emphasize an order or statement. Not long ago the padre was on a trail with two marines. They passed a body of one of those little yellow men. The lead man noticed those slant eyes following them as they passed. He shouted in a streak of profanity—"that * * still alive." Realizing the chaplain was right behind him, he apologized for the crude language. The dismayed padre said hurriedly: "Well, I guess you better shoot the son of a * * before he gets one of us."

Sometimes the boys get on edge. The other day one of the boys was standing in a foxhole with the water and mud up to his ankles. His buddy came up and said: "Get the hell out of that hole with those muddy shoes, that's where I sleep." With a spirit like that the boys don't

have to be fanatics to fight in the superb manner of the typical marine.

The variety of insects is endless. Centipedes five inches long, walking sticks so big they look like limbs off a tree. Spiders as big as one's fist. We're lucky they don't bite. They just scare you to death. The mosquitoes come in formation and waves. The government supplies us with a repellent but these damn mosquitoes don't know it is a repellent, so they bite us anyway.

Malaria, dengue, stutsugamuchi fever and others were just medical curiosities when I studied tropical medicine in school. But they're common diseases out here. I'd like to see a damned good "cold" again. I'd be at a loss to treat it.

I know every medico there is overworked by night calls. We're always very quick to answer "night calls" here. This is one place where everyone is glad to dig ditches for a living. Thought I had a relapse of malaria the other day with the terrific backache. I was glad when I learned it was only a dislocated sacroiliac resulting from a jeep ambulance run I made. I get good pay for just driving an ambulance.

I was amused at some manufacturer's brain storm that he would buy up lots of tents and supplies to sell to ex-service men after the war. He knew they'd be so used to the healthy outdoors they never like to stay home for long. What a sucker, he'll be bankrupt on his opening day!

We get lots of good entertainment to keep up morale (and lose our morals). Where else but here could one run into Bob Hope, Gary Cooper or Mrs. Roosevelt. You fellows have to go to stuffy theaters with canned music and recorded voices. Went to the Gary Cooper show (in person) not long ago. If it hadn't rained so hard I could have heard the jokes and if I hadn't been so far back I could have seen these stars. The guys in the band sitting on the stage said it was a good show.

My asthma is worse. If I were self-prescribing I would say "thirty days in the high altitude of the Ozarks." If you go to the mountains here you might fall into a volcano crater.

Must go to chow. Steaks aren't rationed here. We never even see them. Regards to all there.

Yours,

George F. Stocker,
Lt., M. C., U. S. N.

OBITUARY

JAMES HENDERSON FOWLER, age 69, died at his home in Harrison March 10th. Born near Harrison, the son of a colonel in the Confederate Army, he graduated from Memphis Hospital College in 1907 and had practiced in Harrison since that date. He was the founder of the Boone County Telephone Company and had been active in civic affairs. In addition to serving as president and in the other offices of the Boone County Medical Society, he was for many years Secretary of the Ninth Councilor District Medical Society. Surviving relatives are his wife and three daughters.

COLUMBUS EDGAR GANNAWAY, age 77, died at his home in Warren March 5th. A graduate of the University of Arkansas School of Medicine in 1890, he had practiced in Bradley County for the past 50 years. For many years he had been an honorary member of the Bradley County Medical Society and of the Arkansas Medical Society. Surviving relatives are his wife, a daughter and a son.

COMMUNIQUE

Feb. 11, 1944

To the Editor:

The Journal has been seeping through despite the frequent change of addresses for the past few months.

My unit has been in action for the past few months; being close to the front line we have been able to give the casualties definite treatment as quickly as thirty minutes after being wounded; never over an hour elapsed before they were brought in. The surgeon's ingenuity is sometimes taxed to fit the pieces together.

Have had little experience administering aid to the Japs since the boys on the front give treatment that can't be improved on.

The American soldier in this theater is showing much courage and determination to win the war so that they may return home; this is uppermost in everyone's mind.

Enjoy reading The Journal, especially the communiques giving interesting reading of what the other fellows are doing; their thoughts are the same the world over; to go home for a nice long and happy vacation.

Yours,

Friedman Sisco, Major, M. C.

COMMUNIQUE

February 15, 1944

Dear Doctor Allbright*:

Thank you for your circular letter which I received several days ago. It contained several points of interest to me. I am especially interested in the Wagner bill. Of course, I hope that your predictions hold true and that the bill does not pass this Congress.

I am sorry that the State Health Department has lost Dr. Grayson for he certainly did excellent work while he was State Health Officer and was always most helpful to the doctors.

I hope that we won't be overseas for many more months and can be back in Arkansas to enjoy the practice of medicine.

Yours sincerely,

Frank M. Burton, Major, M. C.

* Letter in answer to letter from President Allbright to all members in service.

COMMUNIQUE

7000 Hollywood Boulevard,
Hollywood 28, California,
March 12, 1944.

To the Editor:

Thanks for your Random Thoughts. I see quite a few names among them that I recall. I wish I was in * * * with Causey. I'll tell you one thing: "It is not true what they say about the Chinese women."

The picture, "The Story of Dr. Wassell," a \$3,000,000 technicolor picture made by C. DeMille is at last finished and will be shown the first time in Washington on April 1st in Constitution Hall. All proceeds go to the Red Cross. This is a Presidential Show under the direction of Secretary Knox.

The premier will take place in Little Rock on April 20th, 1944. Perhaps you know more about the arrangements than I do.

It might be interesting to you to know that Navy Relief will get a quarter million dollars or more from this picture.

Since I have been here the Hollywood Academy of Medicine has made me an honorary member. I have enjoyed the high type meetings they have once a month. I have met some mighty fine people out here. All is not true what they say about stars in movie life, for I have met some folks that are the best in this world. Of course it goes to the head of some, but not all.

Hope to see you in Little Rock.

With very warmest regards to you and all the other boys,

C. M. Wassell, Cmdr., M. C., USNR

COMMUNIQUE

Feb. 17, 1944

To the Editor:

Your thoughts are of conservation; the piece torn off indicates that! 'Tis highly commendable and most patriotic! And speaking of conservation, it is just that of paper that has me perusing reams and reams of directives, circulars, every day until I am spinning. You have, of course, heard of rotation. Well, that is good news copy, but spinning, that is tangible. Red-tape is the name given to it, long ago. So far none of it has convinced Jerry that he shouldn't drop his eggs on hospitals and hospital ships. Or, maybe he got to spinning before he got to the convention rules. Seriously, it is good to hear from you in the "old country" and about the men* in all parts of the world. Have seen Gay several times recently. "Keep 'em coming." Kindest personal regards.

A. M. Washburn, Lt. Col., M. C.

COMMUNIQUE

Feb. 29, 1944

To the Editor:

With apologies I would like to ask that you change my APO to * * instead of * *. I know at times you wish that we would get located for a while, but as you know, nothing would make us happier than to soon return to pre-war mailing addresses.

Have received all my copies of The Journal, only about three weeks late. I appreciate the effort you are making in getting The Journal to us and assure you that I read every page from top to bottom, including the advertisements.

A few days ago I met an officer from Little Rock. Although I had never seen him previously, I felt much better and went about unconsciously smiling for the rest of the day. Have not had the pleasure of meeting any Arkansas physicians over here as yet but understand Robert Young of Little Rock is in the vicinity.

Have received several News Letters to physicians on foreign service. These are appreciated and anxiously awaited. Enjoyed the poem attached to the last one where some thoughtful individual removed the last verse. It was very clever and brought forth a good laugh from each of my officer friends here who read it.

We are depending on you to continue the fight against regimentation of medical practice.

Sincerely,

P. R. Anderson, Capt., M. C.

COMMUNIQUE

March 6, 1944

To the Editor:

To conserve paper and energy (chiefly the latter), I am going to indulge in a slovenly trick and answer on the reverse side of your letter. You had my correct address but you didn't put it all on as there happens to be another naval hospital with the same number. Yes, I am in a country where they give us a lot of mutton under false pretenses and call it lamb. We can't kick about the food here, however, for we get all the fresh meat, milk, vegetables and butter we want, all supplied locally. I thought the letter on the reverse side was very excellent and just the kind of letter the fellows in the service like to get.

I notice in The Journal our annual session will be held April 17th-18th and I regret very much that I cannot be there as it will be the second I have missed for the same reason. I hope to be in the States before another meeting rolls around and sincerely hope I can be there.

I'm not too far away from Krock (for 1500 miles isn't considered far out here in the * * *) and hope that I may be able to see him before I get out of this area. Haven't seen one of our members for many moons now.

With kindest regards,

Sincerely,

R. J. Calcote, Comdr, M. C., USNR

COMMUNIQUE

March 9, 1944

To the Editor:

I surely appreciated your V-mail letter which arrived yesterday. The Journal comes in regularly and keeps us up pretty well on the news.

As to the rumors you have been hearing, I am afraid that they will have to go the way of all scuttlebutt—unfounded. You know one of our favorite songs here is: "There'll be no Promotions, This Side of the Ocean."

Censorship regulations permit me to tell you that I am located as above. It is a typical tropical paradise without the benefit of Dorothy Lamour and her sarong. Previous experience taught the authorities to remove even the native women to another island. We do expect a cargo of nurses shortly which will abolish our nudist colony and somewhat discommode the open latrine and showers throughout the island.

Our hospital is about completed and I guess that I can lay aside my pistol and take up my knife again shortly. I almost feel like one of our men attendants who said that he wanted to resign from the Navy and join the Sea Bees.

Shad Medlin of Little Rock and Fort Smith dropped in for a visit and gave me considerable information. I have also appreciated the various letters from men in our Society over the State. I think that you ought to persuade Earle Hunt to write one.

Sincerely,

Fred Krock,

Lt. Comdr., M. C., USNR

COMMUNIQUE

March 11, 1944

To the Editor:

Received today with pleasure the news bulletin and poem which you sent. The poem was thoroughly enjoyed by myself and colleagues, though some of them were greatly agitated by the deletion. Also received The Journal for February which I enjoyed. Both had done considerable traveling before reaching me.

I do not anticipate having the above address very long but The Journal can reach me there until I send my next address. Saw Major Capel not so long ago. He is the only one from Arkansas I have seen in a long time.

There's not much to say about this place except that it gets very cool at times.

Sincerely,

John H. Pinson, Jr., Capt., M. C.
Station 21 ATC, APO 702,
c/o Postmaster,
Minneapolis, Minnesota

COMMUNIQUE

Feb. 17, 1944

To the Editor:

I'm getting The Journal regularly and also the letters with the dirty jokes which I enjoy.

In the heat of the day not long ago, Milton John of Stuttgart, walked in to see me. We had a nice visit—first Arkansas doctor I've seen down this way, although there are plenty close by.

Our new hospital is open and we are doing a fine paying business—all customers are cash. I have charge of a surgical and orthopedic ward and get many battle casualties. It's a pleasure to work for the boys—they are all young and cheerful, regardless of the type of injury they have.

The Red Cross is doing a fine work and really gets the goods to the boys as well as performs many useful duties for them.

We have an island medical society—over 200 attended the last meeting.

As ever,

Ed Dunaway, Capt., M. C.

PRELIMINARY PROGRAM
TWENTIETH ANNUAL SESSION
WOMAN'S AUXILIARY
TO THE
ARKANSAS MEDICAL SOCIETY
MARION HOTEL, LITTLE ROCK

APRIL 17-18, 1944

HONOR GUESTS OF THE AUXILIARY

Mrs. Eben J. Carey, Wauwatosa, Wisconsin, President, Woman's Auxiliary to the American Medical Association.
 Mrs. Joseph P. Helmick, Fairmont, West Virginia, President, Woman's Auxiliary to the Southern Medical Association.

Dedicated to our Presidents—by Mrs. L. J. Kosminsky
 (Sing to the tune of "Mary")

"For it is Carey, Helmick, Presidents of Auxiliaries,
 Indeed it gives us pride to here preside and welcome you,
 Our inspirations, leaders, for forty-three and forty-four,
 Arkansas welcomes you, you'll find us true,
 May God bless you two."

OFFICERS

PRESIDENT—Mrs. L. J. Kosminsky, Texarkana
 PRESIDENT-ELECT—Mrs. A. C. Shipp, Little Rock
 FIRST VICE-PRESIDENT—Mrs. S. A. Thompson, Camden
 SECOND VICE-PRESIDENT—Mrs. S. A. Drennen, Stuttgart
 THIRD VICE-PRESIDENT—Mrs. C. J. Hinkle, Batesville
 FOURTH VICE-PRESIDENT—Mrs. E. L. Thompson, Hot Springs
 HISTORIAN—Mrs. C. W. Garrison, Little Rock
 PARLIAMENTARIAN—Mrs. W. F. Barrier, Malvern
 POET LAUREATE—Mrs. George B. Fletcher, Hot Springs

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 Dr. O. J. T. Johnson, Batesville
 Dr. E. D. McKnight, Brinkley
 Dr. J. K. Walker, Pine Bluff
 Dr. H. T. Smith, McGehee

COUNCILORS

Mrs. J. B. Crawford, Little Rock
 Mrs. C. E. Kitchens, DeQueen
 Mrs. Alfred Hathcock, Fayetteville
 Mrs. Calvin Churchill, Batesville
 Mrs. L. J. Fincher, El Dorado

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1943-1944

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 EDUCATION AND PUBLIC HEALTH—Mrs. S. A. Drennen, Stuttgart
 HYGEIA—Mrs. C. G. Hinkle, Batesville
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 PHYSICAL HEALTH EXAMINATIONS—Mrs. R. C. Dickinson, Horatio
 MEMORIAL AND CHAPLAIN—Mrs. H. T. Smith, McGehee

DOCTORS' DAY OBSERVANCE—Mrs. C. A. Rosenbaum, Little Rock
 ARCHIVES—Mrs. T. G. Porter, Hazen
 ESSAY CONTEST—Mrs. Pierre Redman, Mena
 CONSTITUTION AND BY-LAWS—Mrs. L. F. Barrier, Little Rock
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 WAR ACTIVITIES—Mrs. N. B. Daniel, Texarkana
 CIRCULATION MANAGER OF THE BULLETIN—Mrs. W. J. Hunt, Warren

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 SECOND—Mrs. O. J. T. Johnson, Batesville
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 FIFTH—Mrs. B. V. Powell, Camden
 SIXTH—Mrs. P. H. Phillips, Ashdown
 SEVENTH—Mrs. H. King Wade, Hot Springs
 EIGHTH—Mrs. R. C. Kory, Little Rock
 NINTH—Mrs. D. L. Owens, Harrison
 TENTH—Mrs. J. L. Kellum, Fort Smith

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ARKANSAS COUNTY—Mrs. E. B. Swindler, Stuttgart
 CRAIGHEAD-POINSETT COUNTIES—Mrs. P. W. Lutterloh, Jonesboro
 CRITTENDEN COUNTY—Mrs. B. M. Stevenson, West Memphis
 FRANKLIN COUNTY—Mrs. E. W. Pillstrom, Altus
 GARLAND COUNTY—Mrs. H. King Wade, Hot Springs
 HOT SPRING COUNTY—Mrs. Raymond McCray, Malvern
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 MILLER COUNTY—Mrs. P. H. Phillips, Ashdown
 MONROE COUNTY—Mrs. E. D. McKnight, Brinkley
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 NEVADA COUNTY—
 OUACHITA COUNTY—Mrs. S. A. Thompson, Camden
 PULASKI COUNTY—Mrs. Randolph Tucker Smith, Little Rock
 SEBASTIAN COUNTY—Mrs. W. F. Rose, Fort Smith
 SEVIER COUNTY—Mrs. Pierre Redman, Mena
 SOUTHEAST ARKANSAS DISTRICT—Mrs. H. T. Smith, McGehee
 UNION COUNTY—Mrs. W. A. Snodgrass, El Dorado
 WASHINGTON COUNTY—Mrs. E. F. Ellis, Fayetteville

PROGRAM

MONDAY, APRIL 17, 1944

Place: Mezzanine Floor, Hotel Marion

9:00 A. M.—Registration

12:30 P. M.—Executive Board Meeting and Luncheon.
 Place: Room 207. Price: \$1.02.

GENERAL SESSION

Place: Parlor "A," Mezzanine Floor, Hotel Marion

2:00 P. M.—Opening of Session: Mrs. Randolph Tucker Smith, President, Woman's Auxiliary to Pulaski County Medical Society.

Invocation—Mrs. B. A. Rhinehart.

Address of Welcome—Mrs. Charles R. Henry.

Introduction of State President—Mrs. L. J. Kosminsky, Texarkana.

Response to Address of Welcome—Mrs. S. A. Thompson, Camden.

Reports of Officers.

Reports of State Chairmen.

INTRODUCTION OF SPECIAL GUESTS

National President: Mrs. Eben J. Carey, Wauwatosa, Wisconsin.

Southern President: Mrs. Joseph Helwick, Fairmont, West Virginia.

Report of the meeting of the Woman's Auxiliary to the American Medical Association, read by the Secretary, Mrs. Harry Murry.

Report of the meeting of the Woman's Auxiliary to the Southern Medical Association, read by the Secretary, Mrs. S. J. Wolferman, Fort Smith.

Announcement of Special Committees—Mrs. Randolph Tucker Smith.

Report of Registration Committee—Mrs. Paul Autry.

Report of Entertainment Committee—Mrs. Carl A. Rosenbaum.

6:30 P. M.—The Pulaski County Medical Society will entertain with a buffet dinner, reception and dance honoring the members and visitors.

GENERAL SESSION

TUESDAY, APRIL 18, 1944

Private Dining Room, Military Club, Basement

9:30 A. M.—Calling the Meeting to Order—Mrs. L. J. Kosminsky, President.

Invocation.

Reading of the Minutes.

Address—Dr. S. J. Allbright, Searcy, President, Arkansas Medical Society.

Report of County Auxiliaries.

Report of the Registration and Credentials Committee.

Greetings from the Woman's Auxiliary to the American Medical Association—Mrs. Eben J. Carey, Wauwatosa, Wisconsin.

Greetings from Woman's Auxiliary to the Southern Medical Association—Mrs. Joseph Helwick, Fairmont, West Virginia.

Election of Officers.

Announcement of the Entertainment Committee—Mrs. Carl A. Rosenbaum.

11:30 A. M.—MEMORIAL SESSION (Joint Meeting with Arkansas Medical Society).

Presiding—S. J. Allbright, President.

Invocation—Rev. S. F. Bryant, Pulaski Heights Presbyterian Church.

Duet—"God Shall Wipe Away All Tears"—Cara Roma. Mrs. Henry Franklin; Mrs. E. Charles Eichenbaum.

Reading of Names of Deceased Members of the Auxiliary—Mrs. H. T. Smith, McGehee.

Address—B. L. Ware, Greenwood, Chairman, Committee on Necrology.

Solo—"The Lord's Prayer"—Mallotte. Mr. George Jernigan.

Benediction—Rev. S. F. Bryant, Pulaski Heights Presbyterian Church.

1:00 P. M.—LUNCHEON—Place: Military Club. Price: \$1.02.

Toastmistress—Mrs. Randolph Tucker Smith—President, Woman's Auxiliary to the Pulaski County Medical Society.

Invocation—Mrs. L. D. Reagan.

Introduction of Past Presidents.

Introduction of State Officers.

Introduction of Wives of Officers of the Arkansas Medical Society.

President's Report (State).

Address—Mrs. Eben J. Carey—Wauwatosa, Wisconsin, President, Woman's Auxiliary to the American Medical Association.

Address—Mrs. Joseph Helwick—Fairmont, West Virginia, President, Woman's Auxiliary to the Southern Medical Association.

Poem—"Excerpts From a War Time Diary"—Mrs. George B. Fletcher—Hot Springs—Poet Laureate.

Unfinished Business.

Report of the Committee on Courtesy Resolutions.

Installation of Officers.

Presentation of Gavel—Mrs. L. J. Kosminsky.

Address of Incoming President—Mrs. A. C. Shipp—Little Rock.

4:00 P. M.—Post Convention Board Meeting.

SPECIAL COMMITTEES—(LOCAL)

ENTERTAINMENT—Mrs. Carl Rosenbaum.

REGISTRATION—Mrs. Paul Autry.

FLOWERS—Mrs. D. A. Rhinehart.

TICKETS—Mrs. Leo Aday.

PUBLICITY—Mrs. Homer Higgins.

COURTESY—Mrs. Paul Eschweiler.

COMMUNIQUE

February 28, 1944

To the Editor:

Just received another army bulletin. You don't know how much we enjoy this letter. It gives us an account of both medical officers and doctors at home.

* * * is an interesting country. It is already hot here. Many of the natives are undernourished and have lots of diseases.

We are all looking forward to getting back to the good old U. S. A., the best place on earth.

Yours,

Ulys Jackson, Capt., M. C.

WOMEN'S AUXILIARY NEWS

The February meeting of the Woman's Auxiliary to the Pulaski County Medical Society was held Wednesday in the home of Mrs. W. F. Smith, with Mrs. Homer Higgins, Mrs. W. A. Snodgrass and Mrs. W. C. Langston, co-hostesses. Mrs. Randolph Smith, president, presided when plans were made for the annual husbands' party to be given in March and for the observance of Doctors' Day in May. Mrs. Carl Rosenbaum, Mrs. Charles E. Oates, Mrs. Hoyt Choate, Mrs. Bryce Cummings and Mrs. T. D. Brown were appointed to serve on the Nominating Committee. Mrs. Gus Allison gave an interesting review of the book, "Good Night Sweet Prince." Forty-three members were in attendance.

BIOGRAPHY

At the Fall 1943 Board Meeting of the Medical Auxiliary in Little Rock, it was decided that the pioneer period of medical history in Arkansas should end in 1881, the date of the first register of physicians and surgeons in the entire state.

It has been the aim of the Biography Committee to gather the interesting bits of history of the pioneer doctors throughout the whole of Arkansas. To date, only Sebastian, Garland, Pulaski and Lincoln Counties have made any headway.

The members of the Woman's Auxiliary to the Arkansas Medical Society should feel that it is important for us to cherish and preserve the records of those medical men who were forerunners of medicine today in Arkansas.

There is no other organization that has this at heart, nor is there any other group of women better fitted to assist in the collection of data on our pioneer doctors, than the wives of doctors.

Although it is impossible to learn very much of these earlier physicians, it would be at least something to learn their names, places and dates of birth, places and dates of graduation, whom they married, where they lived and died in Arkansas. Or, if nothing more can be learned, their names could be listed and the place of residence.

The State has 372 Auxiliary members and we should accomplish something for this Biography. On page 31 of the 1942-43 report of the Woman's Auxiliary to the Arkansas Medical Society there is listed various histories and articles where much data can be found. This should be copied, enlarged if possible, and published in the Journal where such matters belong.

It is suggested that in the observance of Doctors' Day each doctors wife try to bring up the history, or data (typewritten if possible), of at least one pioneer doctor. Much may be accomplished in this way.

"He was the arbiter of death and birth,

The go-between of heaven and hell.

Tender as woman, steadfast as a rock,

Small wonder all the folks loved 'Old Doc!'"

Mrs. Chas. W. Dixon
Mrs. C. W. Garrison

Dear Auxiliary Members:

Your "Doctors' Aide Corps" committee which was added to our Auxiliary program this year would like to give you a little history concerning its origin.

This special wartime service was inaugurated by the Woman's Auxiliary to the Fulton County Medical Society of Atlanta, Georgia, and has been passed on to us through the Southern Medical Auxiliary.

The organization of the Doctors' Aide Corps was the result of an earnest desire to make a definite contribution to the war effort. The program is an ambitious one, the primary purpose being to release as many doctors and nurses as possible for vital war work.

In normal times the doctor gives much time and effort to public health education. In wartime, when demands upon him are so greatly multiplied, some group must come to his aid in this important field. For this purpose, members of the Woman's Auxiliary to the Arkansas Medical Society, who are willing to undergo training

MT. MERCY SANITARIUM

DRUG ADDICTION

As one of its services, Mount Mercy Sanitarium offers facilities for treatment of patients addicted to habit forming drugs. The method is relatively short, requiring seven days. Technic is such that patient is practically free from symptoms of withdrawal during treatment. No Hyoscine used.

MOUNT MERCY SANITARIUM

A. L. CORNET, M. D., Department Director

LINCOLN HIGHWAY—29 MILES FROM CHICAGO LOOP

DYER, INDIANA

The JOURNAL

OF THE ARKANSAS MEDICAL SOCIETY

PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. XL

LITTLE ROCK, ARKANSAS, MAY, 1944

No. 12

MEDICAL EDUCATION IN THE FUTURE

COMMENCEMENT ADDRESS

University of Arkansas School of Medicine
March 27, 1944

VICTOR JOHNSON, M. D.

Secretary, Council on Medical Education and Hospitals,
American Medical Association
Chicago

I deem it a privilege to address you of the graduating class, especially. Associations with students in the college classroom, in premedical studies, in the medical school laboratories and clinics and in my own research problems are among the most stimulating and enriching experiences that may come to any man. If you owe much to your teachers, be sure that they also are indebted to you.

I congratulate you on the completion of this stage in your education: if your training has been worth the effort, you have recognized it as a mere beginning of your knowledge about man in health and disease. Those who do not appreciate this are unworthy of the degree and title which are being bestowed upon you. When you cease to learn, when you cease to search for further knowledge in the dark unknown besetting us and limiting our control of disease and death, you are no longer a physician.

I salute you upon the accomplishment of a task perhaps harder than has ever faced medical students in the past. The study of medicine at any time is arduous, requiring the very best from the best of us. And you are among the best. In no other profession is the ratio of applicants for professional training to available places in the schools as high as in medicine. The competition for this training is keen. Only the best enter the halls of medical learning.

No other graduating class has faced the distracting, disorganizing, discouraging uncertainties which have been your lot. At first the disturbing questions you asked were, "Will Selective Service abruptly interrupt my training? Do I wish to remain in school at such a time? Can I

place full faith in those who say that my duty to my country is to continue the study of medicine? Can I finance myself under this new accelerated program?" Later there were the uncertainties about fulfilling the physical requirements for active duty. There still remain such question as, "How adequate will my hospital training be, with the reduced period of the internship and the probability of no further house officer experience for perhaps years? What will be my assignment in the service? How long will the war last? Will I be ordered to an occupied country after the peace? How many years will it be until I can resume hospital training, or make definite plans for my life-work? Can I get further training when I return? Will I be crowded out by new generations of students seeking advanced training?"

With these persistent doubts, you could scarcely have been blamed had you said, "What's the use? I'll do just enough to get by and hope that circumstances beyond my control will not be too hard on my future."

That you did not take this easy escape, that you persisted diligently in shouldering your responsibilities, is evidence enough that you will be officers of whom we may be proud, and physicians worthy of the honored line of professional and scientific ancestors who have preceded you.

Even before Pearl Harbor the accelerated program which you have followed was being planned, and when war came many schools had completed arrangements to commence the program in 1942 by admitting a new class in July instead of October, and eliminating the summer vacation for students already in school.

At that time, some opponents of the plan said that the first students to enter our medical schools in 1942 under the accelerated program would complete their three academic years and the internship and become available as medical officers at the hopelessly distant date of June, 1946. This was true, but it is also true that Seniors commencing the accelerated program in July, 1942, graduated three months early in March, 1943. These men completed their new nine months internship in December, 1943. Today, because of the accelerated medical school

and the 9-9-9 programs there are several hundred medical officers on active duty in the Army and Navy who would otherwise still be in internships, to continue there until June, 1944. By that time these numbers will be greatly augmented, and, in the months to follow, new thousands of young medical officers will enter into the service early. No one can be so rash as to say that these results may not be one of the crucial factors in the success of the coming invasion of western Europe.

In our thinking about medical education in the future, one of our major concerns is the needs of men like you, who have pursued an accelerated course of training and will go into active duty with only a brief house officer training, and who will return after the war without ever having practiced in civil life. The Council on Medical Education and Hospitals of the American Medical Association considers as one of its major responsibilities the planning to meet the needs of thousands of returning officers in this category.

Over a year ago the Council embarked upon a preliminary study of postwar educational facilities which will be available to these men. Information was sought from nearly 1,300 institutions and agencies, including hospitals, medical schools, departments of health, state medical associations and examining boards in medical specialties. A preliminary report of the findings was published in *The Journal of the American Medical Association* on January 1 of this year. Refresher and review courses, postgraduate lecture and clinic series, and internships and residencies are being developed in many fields, in numbers which give fair promise of meeting the probable demand from returning officers as well as from the more recent graduates who will not have been on active duty.

This study of postwar educational facilities will be continued so that even before the close of the war the Council expects to have ready for distribution a printed list of all educational opportunities available to returning medical officers and especially planned for them.

In the Council's planning for these postwar services it became clear early that we were working entirely on the probable available **supply** of educational opportunities. The question of **demand** for them was entirely unknown, and will depend upon:

(1) What the men now in service will desire after the war. In collaboration with other interested agencies, the American Medical Association, through the Committee on Postwar Medical Services, is obtaining information on this prob-

lem. A questionnaire has been prepared in which are included questions pertaining to the postwar educational desires of medical officers. This is being sent first to 3,000 medical officers. Later it will be sent, with the already assured cooperation of the Surgeons General of the Army, Navy and Public Health Service, to all the 55,000 medical officers in these branches of military service. Information obtained in this extensive undertaking, transferred to International Business Machine punch cards, will be indispensable for intelligent planning.

It may reveal that in some areas the normal number of residents is adequate, and that in other areas it may be necessary to develop new residencies. The study will also reveal approximately how many of these will be needed.

(2) The rate of demobilization of medical officers will bear significantly upon our planning for their postwar training. Should 300 medical officers declare in the questionnaire described that they desire a year of training in (for example) orthopedic surgery, how many residencies in that will be required? If the demobilization is rapid, we shall need 300 residencies. If it is staggered over three years, 100 places may suffice. In the latter event, our present residencies in this field may be adequate. It is obvious that the Council must plan the available postwar educational resources in the light of information made available to us by the Surgeons General of the Army, Navy and Public Health Service on the rate of demobilization of medical personnel. Of this we may be reasonably sure: the young medical officers—those most desiring further training—will be demobilized most slowly. Educationally, this is desirable, so that teachers, who are in the older age group, will be returned first and will be on hand to help in the organization of graduate and postgraduate training for the younger men who will return later.

The problem of providing further training for returning medical officers is a major challenge to all of us at home; hospitals, medical schools, medical societies. It is a debt we owe to the young medical officers in the field, who have given so much more than we have, and upon whom now rests a major responsibility in defeating the enemy. But our duty and high privilege extends beyond this. Entirely apart from casualties, the war will leave the world poorer in brains and skills and training. A failure to plan wisely will not only be breaking faith with youth in medicine, but will be reflected in a poorer quality of medical care, in the health and welfare of the nation and the world for years to come.

In some ways the course of instructions, given to you who are graduating, was irrational and poorly calculated to help you to the best understanding of medicine. This is not because you attended the University of Arkansas, for the same may be said of the educational programs of most if not all of our medical schools. Our philosophy of medical education states that man's body, in health and disease, may be divided into its anatomy, its biochemistry, its physiology, its pathology, and so forth. This highly artificial subdivision of our subject-matter was not planned. It was an accident—an accident of growth. At first there was little more than Anatomy in the curriculum. Anatomy gave birth to daughter sciences including Physiology, which in turn produced the offspring, Physiological Chemistry, and later still another lusty infant, Biophysics. Departments just grew, and the departmental system of instruction just happened. There has resulted a scramble for student time, in which every hour of student time not specifically accounted for in the curriculum is counted as fair game. The department with the most aggressive hunters captures these hours. The successful department is that which has acquired the most hours into which it then crams a maximum of detail whether or not it is relevant.

A more rational and time-conserving program of study is one in which there are no Anatomy, Physiology or Pathology "courses" at all. Instead, the Anatomist, the Physiologist and the Pathologist collaborate in presenting an integrated picture of the body in health and disease, in which accidental repetition is eliminated, and planned repetition incorporated when required. For example, the joint presentation of the nervous system might employ an inter-departmental syllabus of topics, readings, references and laboratory instructions covering the gross and microscopic structure, the normal physiology and the derangements of that system, with the sequence of daily topics being determined by an interdepartmental committee of instructors. I have participated in such a plan at another level of education, the teaching of Biology to college students. The course is a collaborative enterprise in which lectures, discussions and laboratory exercises are given by twenty men from ten different departments, including medicine and surgery. The departmental affiliation and special interests of each instructor are subordinate to the subject-matter of the year's course—Biology. Frequent discussion and criticism of each other by participants in the course have led to a presentation of biology at this level which is far more effective than is possible without

such close collaboration. The success and widespread adoption of such plans in college teaching are stimulating medical educators to think along similar lines. There would be an improved selection of the contents of the medical curriculum, since the material presented by each instructor would be subject to the scrutiny of his colleagues in other fields. The student would better grasp the total picture of medicine, since each instructor would integrate his subject with that of his colleagues in a far more effective manner than is possible under the traditional departmental course system. Student time would be conserved for reading, reflection, investigation, and the pursuit of special interests.

The close interdependence of medical education, medical care, and medical research is asserted much more frequently than it is understood. Medical education has no meaning except as it conceives and meets problems of medical care, not simply in the understanding and control of illness in a given patient, but in fostering an understanding of health as a public asset, and of disease as a foe to be met not only in the patient but in research in the clinic and the laboratory.

There are very naive concepts regarding the role of research in schools of medicine. Trustees say, "Our funds are so limited that they must be employed for teaching; we cannot support research." Presidents say, "Our aim is to produce practicing physicians; we leave research to the Rockefeller Institute, Harvard, the Mayo Clinic." Instructors say, "Teaching occupies my full time and energies. I am employed to teach. I have neither funds, facilities, nor time for research."

In medical education good teaching cannot be divorced from research. Medicine is a complex of experimental sciences and arts, and it cannot be understood unless research is also understood. The student who goes entirely through his medical course learning all the material placed at his disposal, without becoming especially interested in one of the many unknowns he encounters in his studies, has missed something fundamental in his education and vital to his later practice of medicine. The teacher who teaches what is known, however excellently, is remiss as a teacher unless he arouses an impelling curiosity in his students regarding the unknown. This he can scarcely do unless he himself has been sufficiently stimulated to attempt to solve some problem at which he has at least worked earnestly during some of the time remaining after the responsibilities of classroom, laboratory and clinic instruction have been met. I do not mean that all medical schools should try to develop am-

bitious and elaborate research programs. That is impossible even with normal peacetime resources of funds and men. I do mean that the school which considers research and teaching as separate activities, and the teacher who is not inwardly driven to do even a modest amount of research, will only partially accomplish their goals of teaching medicine. With most of our institutions and most of our teachers and most of our students by far the greater emphasis and effort must necessarily be upon mastering the known in medicine. But there must be a leavening of research to convert the dough into bread.

Intensely interested though he may be in his research, the good teacher sees it in its proper proportions and does not commit the error of continually riding his hobby in the classroom. The wise undergraduate student who has become interested in and has found some time for investigation does not neglect his responsibilities as a medical student. A well-balanced program, carrying only the flavor of research, will produce men better qualified to meet the complex problems of medical practice, and better attuned to the progress which will continue to be made in the understanding and control of disease by men who devote most if not all their energies to unsolved problems in biology and medicine.

The very practical consideration might also be mentioned that new faculty members of good quality cannot be recruited unless there are provisions for research. In the main, a department which is sterile in research will be able to enlist new personnel only from the ranks of the less competent, and the less inspiring.

The American Medical Association was founded nearly a hundred years ago for the purpose of improving standards of medical education. When the permanent Council on Medical Education was formed forty years ago, Dr. Arthur Dean Bevan stated that "this is still the most important function of the American Medical Association." At that time there were 160 medical schools in the country. These schools annually graduated 5,606 doctors of medicine. Largely because of the efforts of the Council to enforce high educational standards and to close proprietary schools, the number of institutions was reduced to one-half in the ensuing twenty years. Correspondingly, there was a proportionally great reduction in medical graduates, reaching a low of about 2,500 in 1922. Since that time the number of medical schools has remained almost constant. At the same time, there has been a sustained increase in the number of annual graduates until in the period just

before the war, there were about as many graduates from less than eighty schools as there had been forty years ago from twice that number of schools, many of which were decidedly inferior.

This upward trend in graduates is probably warranted in the cases of those schools which have significantly increased their facilities, faculties, and financial status. But in many cases schools have yielded to pressures for increased enrollment which have not been justified and have resulted in a lowering of the quality of graduates.

It is open to serious question whether there has been an overall 70 per cent increase in our hospital teaching beds, in laboratories, equipment and staff, warranting the 70 per cent increase in graduates which has occurred during the twenty years before the advent of the accelerated program. It was entirely beside the point to argue that more doctors should be graduated because certain areas in the United States were inadequately provided with doctors, even in peacetime. The problem of distributing medical care is distinct from that of the total numbers of doctors. Simply increasing the production of doctors is more likely to increase the crowding of physicians in urban centers than it is to provide doctors for areas needing them most.

There is need for clear thinking on this question. To state that doctors accumulate in large cities because they can make more money there is a naive over-simplification of the problem. The financial reward for services rendered is but one of several important determining factors. Doctors are human beings, and like to live where they may have stimulating professional and intellectual contacts, comfortable home and congenial friends for their families, and good schools and comrades for their children. These factors, sometimes more than financial rewards, are important determining factors in the distribution of physicians and medical care.

Furthermore, doctors like to practice where the essential tools are available. Modern science has multiplied the number of these tools. There must be available to the doctor, X-ray equipment, modern diagnostic laboratory facilities, expert consultation service, and above all, well-equipped hospitals. The economic level in many rural communities, and in many counties in the United States makes it impossible for those communities, unaided, to provide either doctors or the necessary facilities for doctors to carry on their work. At the present time, the United States Public Health Service is assigning and relocating salaried physicians for duty in areas

depleted of doctors, to care for the civilian population. After the war, it may be necessary to continue some such plan for similar governmental subsidies of doctors for areas of low economic status. It also seems clear that hospital facilities will be lacking or will remain at a substandard level in many rural communities in the United States unless there is a considerable extension of state and federal aid for hospital purposes. Although these adjustments may be necessary, they must be recognized as make-shifts. The distribution of medical care is only one aspect of the larger problem of elevating the general economic level of large numbers of our population in peace time. If unemployment is kept as low as now, and production is maintained at the present level after war, and dedicated to the welfare of the people, problems of distribution of medical care will be largely solved.

The term "socialized medicine" is on everyone's tongue these days, and the question is asked, "Will medicine be socialized?" The question more frequently arouses bitter emotions than thoughtful analysis. It is a meaningless question. "Will medicine be socialized?" The answer is that it has already been "socialized" to a considerable extent. Fifty-five thousand doctors—nearly half of those in practice before the war—are now being paid by the federal government as medical officers to give free medical care to ten million men. This is an abnormal war-time situation, but even in peacetime, there is a great deal of "socialized" medicine. The veterans' hospitals and medical services, national, state and municipal public health programs, state and county hospitals, state medical schools with physicians on the faculty paid by the state are forms of socialized medicine. The question is not, "Will there be socialized medicine?" but "How much socialized medicine should and will there be?" The answer to this question will require the best thinking of everyone concerned with the improvement of medical care.

The extension and improvement of medical care is a challenge to medicine, to medical education, to the State of Arkansas, to you here tonight. Your school and your hospital can, and must be instruments for the extension of health and human welfare throughout the State. At the present time the University Hospital is much too small, and too limited in its facilities and resources to do what you would want and should demand that it do. You have the funds, the land, and I trust the vision, to plan now for an expansion of your medical school into a medical

center of which you and the South may be proud. The expansion need not be effected immediately. The building of a medical school, a medical center, and a state health system is not the work of a day. But the plan should be begun today. There should be before the people of this State the vision—translated into sketches, blueprints, and legislative appropriations—of a complete medical center.

The present University Hospital might be employed as an outpatient clinic, after some plastic surgery and face-lifting to bring its architectural lines into harmony with your well-conceived, well-equipped building housing the basic medical sciences.

An enlarged new hospital building, designed to be built perhaps in two or three stages, as funds become available, will return handsome dividends to the state and its citizens from the opening of its doors. You need a well equipped and well housed department of public health and industrial medicine, with the goal of prevention of disease rather than cure. Public health research and its applications have so reduced typhoid fever in many areas that hundreds of medical students and doctors never see a case in their lifetimes. Smallpox and diphtheria are no longer an important problem in many areas. Examples could be multiplied.

But there still remain scourges only now beginning to yield to the persistent attacks of public health measures. Sulfanamide drugs and penicillin are curtailing the ravages of gonorrhea and the new intensive treatment programs for syphilis have given us a potent weapon against this disease. These infectious conditions are liabilities to society and the state which exact an appalling toll of money, unhappiness, suffering and death. They cannot effectively be controlled in the usual doctor-patient individual relationship. Control must center about a well-conceived public health program, carried by such a public health institute as you should have, and should demand, in your new University Medical Center.

New mass methods of locating early cases of tuberculosis in the community, using the small film X-ray technique, have gotten patients into treatment earlier, so that fewer of them require hospital care, and the duration and severity of the infection markedly reduced.

Modern means of rapid transportation will bring the world and its diseases to our doors after the war. The recently issued annual report of the Rockefeller Foundation states: "In former

issues of this Review an account has been given of the successful campaign in Brazil against the dangerous malaria-carrying *Anopheles gambiae* mosquito whose home is in Africa. After high death rates and enormous suffering, and with great labor and cost, it can be said with confidence that the *gambiae* species was eliminated from Brazil.

"The Foundation was therefore disturbed to receive, during 1943, advices from its representatives in Rio de Janeiro that *gambiae* mosquitoes, some of them alive, had been found on planes coming from Accra and Dakar in Africa to Natal. Even more disturbing was the news that five live *gambiae* had been discovered in dwellings near the Natal airport. Incoming planes from Africa are, of course, fumigated both before they leave Africa and before they land in Brazil, but a few mosquitoes were evidently able to stow away safely in the modern, complicated airplanes. When it is realized that a single fertilized *gambiae* could start a conflagration similar to that which swept north from Natal in the thirties, the danger of the situation becomes apparent.

"Thanks to the efforts of the Brazilian and United States authorities, the immediate situation is now in hand. But it poses a problem of larger significance which cannot be evaded. Around the ports of Africa and deep within the hinterland lie the breeding centers of the *gambiae*. The safety of the Western Hemisphere, which is now within a few hours' flight across a narrow ocean, can no longer be left to the uncertainties of a flit-gun campaign. Modern airplane travel has made old methods and ideas of quarantine completely obsolete."

Returning soldiers will carry back infectious organisms usually confined to the tropics, and we shall see more of many tropical diseases. Malaria will probably be more widespread than ever before, and will require vigorous public health and sanitary measures for its control. Measures instituted in the Southern states during the past ten years have forcibly demonstrated that adequate control can be effected.

The war has brought home to us in startling fashion the widespread extent of emotional disorders in our population. We have long known that hospital beds for nervous and mental cases exceed in numbers those for all other conditions requiring hospitalization combined.

Now we are learning that emotional disturbances are the leading cause for discharges from the army. The seriously disabling effects of ma-

laria, and the multiplying incapacities from combat injuries are lesser causes of separation from the services than are these neurotic disorders. This is particularly true of men who have been in service for less than six months and before they engage in actual combat activities. This is a serious indictment of our peacetime preventive measures against faulty personality development. But it is only part of the unhappy story. These men who break down in the service have already passed physical and psychiatric examinations. Per hundred inductees into the service, the number who fail to be inducted for psychiatric reasons is far greater than the number of inducted men who cannot later adjust to the strains of military life.

While not severe enough to be obvious under the lesser strains of civilian life, these disorders must certainly have seriously affected the efficiency and happiness of far more men and women than we have heretofore suspected. This problem is one of more than immediate military importance; it is of utmost importance in civilian life now and after the war. Neglect of this immense public health problem in the planning of any medical school and state hospital system cannot be condoned by any state which aims at the good life for all its citizens.

Your medical center should include a psychiatric institute which is concerned primarily with the mild, partially incapacitating emotional disturbances rather than with the more severe psychoses provided for at the Arkansas State Hospital for Nervous Diseases. Intensive consideration of these milder cases in a combined research, teaching, therapeutic and preventive program promises greater returns to the community and the State, because these conditions are more readily preventable and amenable to treatment.

In conclusion, I again congratulate you of this medical class of March, 1944, upon your opportunities and responsibilities. Yours is the responsibility to help save the world in the war and the opportunity to remake it in the peace to follow. It will be for you to improve medical care through improving medical education and fostering if not yourself carrying on research. You must extend medical care to everyone who needs it through cooperative enterprises with industry, labor, government and the public.

You are well prepared to meet the responsibilities ahead as medical officers during the war and later as civilians in the endless war of science and medicine against disease and death. We know that you will give your best. I welcome you into the noblest of the professions.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

THE emphasis on early diagnosis of pulmonary tuberculosis would seem to be wasted if effective treatment is unnecessarily postponed. Discriminating selection of cases for collapse therapy, skillful choosing of the appropriate method and prompt employment of the elected procedure are indicated in the interest of all concerned.

INTRAPLEURAL PNEUMONOLYSIS

It seems generally agreed that at least half the cases of pulmonary tuberculosis require some form of collapse treatment, either reversible or irreversible. Thoracoplasty is the best surgical example of the latter, while the oldest technique devised—pneumothorax—is a good representative of temporary, reversible collapse of the lung.

The chest specialist is the one to select either method after he has evaluated the patient's condition and the stage of his tuberculosis. The mistaken belief that "time heals everything" must give way to acknowledgment that this disease demands immediate consideration invariably and active methods of treatment whenever indicated. In this race against time, presence of a cavity calls for measures to obliterate it before delay invites a hemorrhage or spread results in a hopeless condition.

Pneumothorax remains the first choice, but is successful in only about half the cases in which it is initially tried. Lack of success may be attributed to adherence of the two pleural surfaces so that collapse of the cavity is impossible or incomplete. Delay in the institution of pneumothorax may allow the parenchymal inflammation to progress and involve the pleurae until adhesions form and so defeat later attempts at what should have been a simple collapse procedure.

Formerly, a risky method attempted to stretch or break such adhesions by forcing air into the pleural cavity under positive pressures. Serious complications developed if the adhesion, breaking off near the lung, tore the latter so that a tuberculous or mixed infection empyema resulted. Serious hemorrhage might follow rupture of a sizeable vessel incorporated in the adhesion. Precious time was often wasted while the hoped-for stretching of the adhesion was awaited. Meanwhile the still unaffected cavity might supply bacilli to cause other cavities elsewhere.

Intrapleural pneumonolysis was designed to transform, where feasible, a poor pneumothorax result into a satisfactory effective collapse. Under local procaine infiltration anesthesia, a special cannula is introduced between the ribs into the pleural space, transmitting a visual instrument not unlike a cystoscope. Through this the operator views the interior and by means of a cautery inserted through a second cannula in another interspace severs the adhesions under direct vision.

Adhesions vary in size and shape and may be multiple. They range from "fiddle string" to short, thick and cylindrical, or may resemble accordion pleated sheets that radiate in all directions and run all the way from paper-thinness up to bands one or several centimeters in diameter. In using the cautery it is necessary to remember that thicker adhesions may contain lung tissue or large blood vessels and that they may be attached firmly to the aorta, subclavian artery or vital mediastinal structures. Great skill is required to avoid disasters similar to those already listed above as chargeable to stretching and rupture of adhesions.

A skilled operator will sever an adhesion as near its parietal extremity as possible, thus protecting the lung while exercising due caution as regards the intercostal structures as well, especially if actual dissection in the latter area proves necessary. In competent hands, backed by adequate experience and judgment when and when not to cut, the operation is a minimal one as regards the patient's discomfort. In less experienced hands, however, it can present dangers exceeding those of almost any other major intrathoracic surgical procedure.

When a pneumothorax is started and adhesions can be seen to interfere with collapse, provided the space is large enough for the surgeon to manipulate his instruments, there is no

reason for delay. Besides the well-known hazards of an open cavity, the longer one waits the thicker grows the pleura covering the bands and the greater the difficulty of cutting them.

Very large adhesions may have to be severed partially at one sitting and finished in stages after waiting periods of three or four weeks have intervened. Adhesions too widespread to submit to this method call for abandonment of the unsuccessful pneumothorax and the selection at once of a collapse procedure other than pneumonolysis.

Summary

1. Remember the time factor and begin active pneumothorax treatment immediately upon an individual who has a cavity. Don't wait to see what happens to the case with prolonged bed rest. Too often the realization will be accompanied by disappointment and chagrin.

2. In about half the cases a pneumothorax will be complicated by adhesions.

3. Don't attempt to stretch adhesions by means of a positive pressure pneumothorax.

4. Make an attempt to sever them by intrapleural pneumonolysis—again remembering the importance of time—as soon as possible.

5. In the hands of an expert, the unfavorable consequences of the operation are insignificant and the complications rare, but when performed by one with little experience, the dangers are very real.

6. If it is impossible to improve the collapse by pneumonolysis, abandon the pneumothorax and perform a thoracoplasty.

Intrapleural Pneumonolysis, Lt. Comdr. James E. Dailey, M. C., U. S. N. R., *Diseases of the Chest*, Nov.-Dec., 1943. (Reviewed and passed by The Bureau of Medicine and Surgery, U. S. Navy.)

COMMUNIQUE

March 15, 1944.

To the Editor:

Received "Random Thots—Service Edition—January, 1944," today. As ever, I was glad to get your letter. These letters are always full of information and always contain a good joke.

Please note my above address and change my mailing address so I will receive your letters more quickly.

Sorry that I can't say more, but I just haven't been anywhere and I haven't seen or heard a thing lately.

Sincerely,

R. L. Turnbow,
Capt., M. C.

COMMUNIQUE

March 20, 1944.

To the Editor:

Please change my address from that of overseas to the good old U. S. A. "Down Deep in the Heart of Texas," and I'm not one of the 100 doctors sent out of Arkansas and Louisiana to take the "clap" out of the Heart of Texas.

By some obscure mechanism, fortunately for me, for the past two years, all The Journals addressed to me have been via Fort Bliss, Texas, part of the time, the rest via A.P.O. 939, Seattle, Washington. For the past seven months I still receive them via overseas route and I enjoy them now as I did overseas. It's just like receiving a bundle of letters from Arkansas. That piece of paper torn half into was cagey. Who's the author?

If you see Major Stanley Gates in and around, or about Camp Chaffee, give him my regards. He was my regimental surgeon.

T. J. Raney, Chas. Brown, Leverett and Henry are here.

I am assigned duty in E. E. N. T. clinic and as a ward-officer. Like it swell, particularly being back on U. S. A. soil and with my family.

Regards to all,

Robert M. Kelly, Capt., M.C.,
Station Hospital,
Camp Hood, Texas.

COMMUNIQUE

March 31, 1944

To the Editor:

Am forwarding a copy of YANK to you today under separate cover. This one is a little back date but will send another at time of next delivery. Will send a Guinea Gold.

Down here in the jungle The Journal and the news letters are most welcome. Rosie McQueen and the cat stories were new to us so we enjoyed them. You are to be commended for your efforts and when we return will reward your efforts by some tall stories.

Saw Jim Walls in * * * and talked to Fulmer over the phone. Erner Jones is with this division. Just missed Wickard before he went into action.

* * * is a great country. I had the opportunity to see a great deal of it and the high spot was * * *. I had a week's leave there and found it most enjoyable. The Yank is entertained royally there and no holds barred.

Remember me to Dr. Allbright when you see him. Best wishes to you.

Sincerely,

Hugh Mobley, Maj., M. C.

THE JOURNAL

OF THE

ARKANSAS MEDICAL SOCIETY

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under direction of the Council

W. R. BROOKSHER, M. D., Editor
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EDITORIAL

THE ANNUAL SESSION

With a total attendance of 301, 229 of whom
were members of the Society, the second war-
time session of the Arkansas Medical Society
convened in Little Rock April 17-18th. Under
present conditions, it was felt that this attend-
ance testified to the value of medical meetings
in war-time and to the individual member's
interest in his state society. The scientific pro-
gram was a well-rounded one and ten excellent
papers were presented. Guest speakers were
Neal Owens, Donovan C. Browne and Rawley
M. Penick, Jr., of New Orleans. Opportunity
was afforded the members of the host society,
the Pulaski County Medical Society, to royally
entertain the members and guests at the annual
banquet session. Officers elected were: Presi-
dent, Jos. F. Shuffield, Little Rock; President-
Elect, C. A. Archer, DeQueen; First Vice-presi-
dent, Hoyt R. Allen, Little Rock; Second Vice-
president, H. E. Murry, Texarkana; Third Vice-
president, Fred Hames, Pine Bluff; Treasurer,
Paul L. Mahoney, Little Rock; Secretary, W. R.
Brooksher, Fort Smith; Delegate to the American
Medical Association, S. J. Wolferman, Fort

Smith; Alternate to the American Medical Asso-
ciation, S. J. Allbright, Searcy; Councilors, Sec-
ond District, L. T. Evans, Batesville; Fourth Dis-
trict, M. C. Crandall, Wilmot; Sixth District,
C. E. Kitchens, DeQueen; Eighth District, M. J.
Kilbury, Little Rock, and Tenth District, Clyde
McNeil, Rogers. The new Council elected H.
King Wade, Hot Springs, Chairman. The 1945
meeting place will be selected later by the
Council.

TUBERCULOSIS POSTGRADUATE STUDY

The Journal again calls attention to the gener-
ous offer of State Tuberculosis Sanatorium
through Dr. J. D. Riley, superintendent, to make
the entire facilities of this institution available
to the physicians of Arkansas for study in all
procedures connected with the diagnosis and
treatment of tuberculosis. Physicians are wel-
come and quarters will be furnished those who
wish to remain at the institution for a period
while engaged in a study of methods in use at
the Sanatorium. The weekly schedule of medical
activities at the Sanatorium is as follows:

Monday A. M.: Pneumothorax and surgery (in-
trapleural pneumolysis, phrenic exeresis, etc.).
Tuesday A. M.: Pneumothorax.
Tuesday, 2:00 P. M.: Preliminary staff meeting.
Wednesday, 9:00 A. M.: Regular staff meeting.
Thursday A. M.: Surgery.
Friday A. M.: Pneumothorax.
Saturday A. M.: Surgery (intra-pleural pneu-
molysis, etc.).

COMMUNIQUE

March 28, 1944.

To the Editor:

Who said "nor do four walls a prison make?"
That bird would retract that statement if he'd
served my time on a G. I. hospital ward. Expect
a disposition soon, however, if none of the N. P.
boys see me around.

You were beefing in your last letter because
no one sent you "Yank" or other G. I. publica-
tions. I mailed you the current "Yank" then
thought of suggesting that you get one from
Chaffee too late to save my wrapping time,
to say nothing of the 3c postage. Seriously, ask
somebody in India to send you "The C. B. I.
Roundup." It is a much better publication.

Sincerely,
W. L. Shippey, Capt., M.C.,
Winter General Hospital,
Topeka, Kansas.

PROCEEDINGS OF SOCIETIES

Craighead-Poinsett County Medical Society was addressed April 6th by Capt. Kahan, Walnut Ridge Air Field, "Present Status of Immunization," and H. L. Ledbetter, Jonesboro, "Some Actions, Indications and Dosage of Plasma."

J. H. McCurry, Secretary.

The Sebastian County Medical Society was addressed April 11th by I. F. Jones, "Caudal Analgesia in Obstetrics."

D. W. Goldstein, Secretary.

Lincoln County Medical Society has elected the following officers: B. L. Bailey, President; G. C. Wood, Vice-president, and Chas. W. Dixon, Secretary.

Howard-Pike County Medical Society has elected T. F. Alford, President; J. L. Roberts, Vice-president, and M. D. Duncan, Secretary-treasurer.

Benton County Medical Society met in dinner session at Bentonville, April 7th, for the following program: "Blood Bank," Guy Hodges, and "Farm Security Administration Medical Care Program," J. S. Thompson.

Geo. M. Love, Secretary.

Boone County Medical Society has elected the following officers: President, M. E. Rust, Harrison; Vice-president, W. H. Poynor, Harrison; Secretary-treasurer, Ross Fowler, Harrison; Delegate, Ross Fowler, and Alternate, D. L. Owens.

Lee County Medical Society has elected the following officers: President, C. W. Chaffin, Moro; Secretary-treasurer, N. C. Hodges, Marianna, and Delegate, C. W. Chaffin.

The First Councilor District Medical Society met in dinner session at Jonesboro March 23rd for the following program: "The Acute Surgical Abdomen," E. M. Holder, Memphis, and "Gonorrhea," P. S. Pelouze, Newark, N. J. J. H. McCurry, Cash, was re-elected secretary-treasurer.

Clay County Medical Society has elected the following officers: President, N. J. Latimer, Corn-

ing; Vice-president, O. H. Clopton, Rector; Secretary-treasurer, J. E. McGuire, Piggott; Delegate, F. H. Jones, Piggott, and Alternate, O. H. Clopton.

Jefferson County Medical Society has elected the following officers: President, T. J. Cunningham, Jr.; Vice-president, Virgil Payne; Secretary-treasurer, Charles W. Reid; Delegate, W. T. Lowe, and Alternate, W. H. Bruce.

Drew County Medical Society has elected the following officers: President, J. P. Price, and Secretary-treasurer, L. F. Billingsley.

Pulaski County Medical Society entertained with its annual President's Dinner April 16th honoring President S. J. Albright. Past-presidents in attendance were: M. L. Norwood, Lockesburg; Robert Caldwell, Little Rock; W. T. Wootton, Hot Springs National Park; E. E. Barlow, Dermott; D. A. Rhinehart, Little Rock; W. H. Mock, Prairie Grove; L. J. Kosminsky, Texarkana; M. E. McCaskill, Little Rock; Geo. B. Fletcher, Hot Springs National Park; O. J. T. Johnston, Batesville; S. J. Wolferman, Fort Smith; A. S. Buchanan, Prescott; H. T. Smith, McGehee; H. Fay H. Jones, Little Rock, and R. B. Robins, Camden.

Conway County Medical Society has elected J. F. Halbrook, Plumerville, President, and T. W. Hardison, Morrilton, Secretary.

Crittenden County Medical Society has elected the following officers: President, L. C. McVay; Secretary-treasurer, T. S. Hare, Crawfordsville; Delegate, B. M. Stevenson, and Alternate, L. C. McVay.

COMING MEDICAL MEETINGS

Second Councilor District Medical Society, Batesville, May 8th.

Fifth Councilor District Medical Society, Magnolia, May 16th.

Ninth Councilor District Medical Society, Harrison, June 7th.

American Medical Association, Chicago, June 12th-16th.

PERSONALS AND NEWS ITEMS

Capt. Robert M. Kelly, Sheridan, formerly stationed overseas, is now on duty at Station Hospital, Camp Hood, Texas.

Lt. Harlan H. Hill, Little Rock, is now stationed at Borden General Hospital, Chickasha, Okla.

Capt. William M. Kober, Little Rock, is now stationed overseas.

Capt. Ben H. Pride, Fort Smith, has been assigned to Camp Hulen, Texas.

F. Walter Carruthers, Little Rock, spent a recent vacation in Phoenix, Arizona.

Riley Cowan has moved from London to Van Buren.

C. H. Lutterloh, Hot Springs National Park, now stationed at Camp McCoy, Wisconsin, has been promoted to lieutenant-colonel.

Capt. Richard W. Miller, Fayetteville, is now stationed overseas with a general hospital.

Maj. S. B. Thompson, Camden, is now stationed overseas with a general hospital.

Lt. Chas. P. Harris, Jonesboro, is now stationed at Lovell General Hospital, Fort Devens, Mass.

"Post Caval Ureter" by Carl L. Wilson (Fort Smith) and Jacob Herzlich, appeared in The Journal of Urology for January, 1944.

D. A. Mohler has moved from Palestine to Brinkley.

Fred Hames, Pine Bluff, conducted a diagnostic cancer clinic at El Dorado recently under the auspices of the Union County Medical Society and the Women's Field Army.

The following attended the American College of Surgeons conference in Tulsa April 4th: Earle H. Hunt, Clarksville; H. E. Mobley, Morrilton; Roy I. Millard, Russellville; R. M. Eubanks, Jos. F. Shuffield and J. Harry Hayes, Little Rock, and S. J. Wolferman, Ralph E. Crigler, and H. H. Smith, Fort Smith.

H. L. McLendon has moved from Palestine to Forrest City.

Jabez F. Jackson, Walnut Ridge, now stationed overseas, has been promoted to major, and is serving as chief of medical services in a general hospital.

Capt. Garland D. Murphy, Jr., El Dorado, is now stationed overseas with a bombardment squadron as flight surgeon.

Lt. Wm. J. Butt, Fayetteville, is now on duty with the 44th Hospital Train, Camp Gruber, Oklahoma.

L. T. Evans has been elected vice-president of the Batesville Rotary Club.

A. S. J. Clarke has been elected an elder in the Conway Presbyterian Church.

Mr. John G. Pipkin, Commissioner, and Dr. Vida H. Gordon, Medical Director of the Crippled Children's Division of the State Department of Public Welfare, announce the appointment of a Technical Advisory Committee for the State Crippled Children's Program. Members of this committee were suggested to this agency by the president of the Arkansas Medical Society.

An effort has been made in so far as possible to include on this committee representatives of the various branches of medical practice and to secure geographic representation for the state. The members as appointed are as follows:

Dr. Joe Shuffield, Little Rock; Dr. P. W. Lutterloh, Jonesboro; Dr. Paul Mahoney, Little Rock; Dr. B. C. Middleton, Texarkana; Dr. R. A. Law, Little Rock; Dr. T. T. Ross, State Health Commissioner, Little Rock; Dr. S. J. Wolferman, M. D., Fort Smith; Dr. Belle Dale Poole, El Dorado, Arkansas; and Dr. Samuel Allbright, President, Arkansas Medical Society, and Mrs. J. A. Pickens, R. N., First Vice-president of the State Nurses' Association, Little Rock.

The purpose of this committee is to serve the important function of assisting the Crippled Children's Division in establishing and maintaining standards of medical care and to insure cooperation with the medical profession of the state.

The annual meeting of the Arkansas Tuberculosis Association in Little Rock April 11th was addressed by A. C. Curtis, Little Rock, "Responsibility of Official and Voluntary Agencies in the Control of Tuberculosis"; L. A. Wilcox, Little Rock, "Tuberculosis in Industry, and N. T. Hollis, Little Rock, "Tuberculosis in the State

Hospital for Nervous Diseases." Officers elected are A. C. Shipp, Little Rock, President; J. D. Riley, State Sanatorium, Vice-president; Jerome S. Levy, Little Rock, Secretary, and Directors, R. M. Eubanks, Little Rock; H. A. Higgins, Little Rock; T. T. Ross, Little Rock, and E. J. Munn, El Dorado.

Maj. L. M. Henry, Fort Smith, has been transferred to Brookley Field, Mobile, Alabama.

R. B. Robins addressed the Men's Club of the First Christian Church, Camden, April 18th, on "War and Medicine."

Maj. Wm. B. Harrell, Little Rock, has been appointed chief of surgical service in the 368th Station Hospital, now overseas.

Capt. Carl R. Williams, Morrilton, is now stationed overseas.

Lloyd F. Ritchey, Camden, has been appointed Lieutenant, Medical Corps, Army of the United States, and assigned at Carlisle Barracks, Pennsylvania.

W. H. Martin has been elected vice-president of the Holly Grove Rotary club.

Lt. Harlan H. Hill, Little Rock, is now stationed overseas.

Lt. Leslie G. Holt, Little Rock, is now stationed at Lovell General Hospital, Fort Devens, Massachusetts.

F. Walter Carruthers, Little Rock, was guest speaker at the annual session of the Louisiana State Medical Society, New Orleans, April 26th, speaking on "Management of Shaft Fractures of the Long Bones."

Capt. Hunter C. Sims, Blytheville, is now stationed overseas.

Maj. Walter D. Easterling, Lake Village, is now stationed overseas.

J. B. Jameson has been elected vice-president of the Camden Rotary club.

Capt. Frank M. Adams, Hot Springs National Park, is now stationed with the 163rd Station Hospital, Somp Claiborne, Louisiana.

RANDOM THOUGHTS OF THE SECRETARY

March 27th. A considerable accumulation of medical talent (Jones, Foster and us), not to mention the helpful suggestions of the patient, fails to solve Wolferman's sudden indisposition tonight and who would have thought that there would finally devolve the thought that an allergic reaction to pickled onions would be the cause?

March 29th. With merriment and much gay conversation gathering tonight on Chamberlain's natal day as he progresses into the chronological period assigned to over-age destroyers.

March 31st. Culminating our efforts in behalf of the Red Cross fund pleased that our professional colleagues have made substantial contribution, excelling all other groups in amount paid to a worthy cause.

April 16th. Arriving the convention city and at work with the preliminary affairs of the meeting, noting that the hotel is publicizing our session as well as a meeting of some sort of urologists and proctologists, the water and sewerage fellows. Tonight the council meets and well it is for there would not have been sufficient time in a two-day session to get along with the business of tonight. Later for a discussion of Bob Robin's candidacy in which he has great hopes and for some scientific medicine with guest speakers, Browne and Owens.

April 17th. Early they come to register and specially welcomed are the boys on leave, Maj. T. Duel Brown, Maj. Byron Bennett, Lt. Thomas P. Foltz and Capt. James M. Kolb. Reports are well presented and Wolferman sees his presidential address recommendation of some years back finally adopted as a constitutional amendment relieving the nominating committee of a great part of the grief and, in thanks therefor, this committee promptly selects its candidates. Tonight there is a gay party with the Pulaski County members as joyous hosts and there is a good time for all.

April 18th. Somewhat delayed with the morning session but it is still agreed that the memorial session is best held at a later morning hour. The past-president's breakfast this morning has more than the usual absentees, especially from the host city, but Wootton's early arrival is doubtless compensatory. President Allbright takes off from the morning session, doubtless because of "jitters" over his address to the Auxiliary. The House of Delegates closes its work without undue discussion and we pack up as the 1944 session becomes history. Cogitating over the activities of the meeting we are more firmly convinced that Roger Lee was right when he said that a state society secretary "walks a thin line between officiousness and efficiency." With a short postmortem with Shuffield, Jones, Kilbury and the Wolfermans, off to Conway for dinner and on home grateful for the men of medicine in Arkansas and their works.

COMMUNIQUE

March 18, 1944.

To the Editor:

Take my name off that list! The January "Random Thots" just caught up with me. The letter had really been places before it reached me. Some of them! Well, I've never been there

yet! I didn't know until now there were enough doctors left in Arkansas after that flock of letters that went out about June of 1942 to make any difference.

There is very little I can tell you about myself now without offending someone. So will try to stay by Post and Hoyle and a few facts. I am a flight surgeon somewhere in . . . I enjoy my work but would relish a call on a cold rainy night back in the Ouachita River bottoms if I could get Adolph to quit. I have enough work to do to keep me more than busy. See plenty of interesting medical cases and do a little minor surgery, enough of each to keep me feeling like a doctor. Have opportunity quite often to attend medical meetings, clinics. That is one thing I didn't expect. These meetings and clinics are keeping the army doctors in close contact with new trends in medicine so I believe the talk of having to take postgraduate and refresher work after the war, with some exceptions, won't be necessary.

Enough of that. The food here is certainly more than I expected (even ice cream). It's so good that I am afraid the 1945 class reunion of mine will find people wondering who the owner of the prodigious girth could be. The people are just what I expected, quite like us, in a matter of fashion. About two weeks ago I was Medical O. D. and had gone to bed early. About 10:30 p.m. I was awakened by loud noises, talking and confusion, apparently. At first I thought I was dreaming but it all continued, so I sat up, rubbing my eyes and asked what the — goes on. Well, there they were right out of . . . , the two of them. The father, a little old man, handle-bar "stash," rosy cheeks, stooped shoulders and clothes that swallowed him. The son, taller; pale, ascetic face, and his knee pants should have lifted him off the floor. He hopped around like a flea, saying, "Yes, father; yes, father," that would have put a Hollywood "yes" man to shame. It seemed they had a bit of hammering to do the next day and they thought they would get an early start.

Have been to . . . once and must say that Hitler lied to me. I thought he hadn't left enough that I couldn't see in one visit. Now it will probably take three or four more, anyhow.

Will try to write more soon!

Sincerely,

Garland D. Murphy, Jr.,
Capt., M. C.

WOMEN'S AUXILIARY NEWS

The Woman's Auxiliary to the Pulaski County Medical Society met Wednesday in the home of Mrs. W. Schwartz, with Mrs. Charles Henry, Mrs. Daniel and Autry, Mrs. Nye Compton and Mrs. Paul Fulmer, co-hostesses. Mrs. C. W. Garrison and Mrs. Randolph Smith served in the dining room at the luncheon preceding the business session presided over by Mrs. Smith, president. Members voted to contribute \$10 to the Red Cross drive and final plans were completed for the dinner to be given March 24th at the Y. W. C. A. honoring husbands. Miss Mary Scott, consultant nutritionist for the State Health Department, spoke on "Food and Its Importance to Good Health." Mrs. Carl Rosenbaum, chairman of the Nominating Committee, presented the following members who were elected officers for the coming year: Mrs. Paul Autry, president; Mrs. Charles Henry, first vice-president; Mrs. Vernon Newman, second vice-president; Mrs. Paul Fulmer, secretary; Mrs. P. C. Eschweiler, treasurer; Mrs. Schwartz, publicity chairman; Mrs. V. T. Webb, parliamentarian, and Mrs. Leo Aday, historian. Mrs. Rosenbaum will entertain the club April 12th.

The Auxiliary to the Pulaski County Medical Society entertained their husbands on "Doctor's Day" with a dinner in the private dining room of the Y. W. C. A. Chicken dinner was served on long beautifully appointed tables, decorated with yellow collard blossoms and greeneries with tall green candles in crystal holders in the center of each table. At the conclusion of the dinner, a mock broadcast of "Truth and Consequences" was given, conducted by Mrs. R. C. Kory with Mrs. P. C. Eschweiler and Mrs. Leo Aday assisting, using different members of the Medical Society and Auxiliary as contestants, each contestant being awarded a prize of thrift stamps. Other prizes were won by Mrs. C. E. Oates and Dr. Byron Robinson in a skit "Off to Buffalo" with music in charge of Mrs. Hoyt Choate.

Mrs. Homer Wiggins,
Publicity Chairman.

Mrs. B. L. Ware was elected president of the Auxiliary of the Sebastian County Medical Society at a luncheon meeting of the Auxiliary April 10th. She succeeds Mrs. W. F. Rose who becomes vice-president.

The other officers elected are Mrs. S. P. Stubbs, secretary, and Mrs. Walter G. Eberle, treasurer. They will be installed at the May meeting of the Auxiliary.

Mrs. M. E. Foster, Mrs. D. W. Goldstein and Mrs. J. S. Southard, the nominating committee, presented the officers.

Mrs. Rose presided at the luncheon and the business session. Hostesses were Mrs. B. L. Ware and Mrs. S. P. Stubbs.

Delegates and alternates were named for the state meeting of the Arkansas Medical Society's Auxiliary to be held in Little Rock April 17th and 18th. The Auxiliary meeting will be in conjunction with the Arkansas Medical Society's sixty-ninth annual meeting. Mrs. W. R. Brooksher, Jr., and Mrs. S. J. Wolferman were named delegates. Alternates are Mrs. B. L. Ware and Mrs. Walter G. Eberle. The Auxiliary and medical society will hold a joint memorial service at 9 a. m., Tuesday, April 18th. Dr. B. L. Ware will deliver the memorial address. The Pulaski County Medical Society will entertain the physicians and Auxiliary members with a buffet dinner, reception and dance in Hotel Marion, convention headquarters, at 6:30 o'clock Monday evening, April 17th. Mrs. A. C. Shipp, a Little Rock woman, is scheduled to take office as president, succeeding Mrs. L. J. Kosminsky, Texarkana. Mrs. Shipp was named president-elect at last year's convention.

Members present for Monday's meeting were Mabel Wood Scott, Mrs. Eugene Stevenson, Mrs. S. P. Stubbs, Mrs. S. J. Wolferman, Mrs. A. A. Blair, Mrs. M. E. Foster, Mrs. Walter G. Eberle, Mrs. D. W. Goldstein and Mrs. W. F. Rose.

COMMUNIQUE

March 28, 1944.

To the Editor:

I guess that my denial of a promotion was a little bit previous, and in the interests of accuracy, I rewriting my answer to you. About three days ago it became official out here and I donned the silver leaf, but can't get any scrambled eggs for my hat. Powdered eggs won't work. They dated it back to August 20, 1942, which puts me back in the running.

The hospital has opened and we are beginning to make our expenses. We have all the facilities of a standardized hospital including a bevy of nurses (G. I. Navy issue), who recently arrived.

I guess you will be seeing Jim Amis shortly. Say hello to him for me and get together to help me wet it down.

As ever,
Fred H. Krock,
Comdr., M.C., U.S.N.R.

COMMUNIQUE

March 15, 1944.

To the Editor:

This afternoon when The Journal arrived, I was surprised to find that my name was listed among those whose addresses were wanted. Surprised, because my copy of The Journal has arrived regularly for the twenty-three months that I have been overseas. It is true that my address is incorrect and it has been due to the perfection of our postal service that it reached me. The Journal means a great deal to me and I am sending my corrected name and unit designation. I sincerely appreciate your efforts to insure the delivery of The Journal.

Yours very truly,

Howard M. Armstrong,
Capt., M. C.

COMMUNIQUE

March 22, 1944.

To the Editor:

Just received your March edition of Random Thots which is always appreciated in these parts. In order to keep it coming to me regularly and as quickly as possible, I wish to call your attention to the change in organization, a fact not noted on my last change of address due to one of those mysterious decisions so puzzling to us do-what-they-say-without-questions fellows.

You mentioned that Ewing Nixon was in Wai-kiki and possibly lolling around in that Chamber of Commerce luxury the vacation folders tell about. If I may have it, please send me his address in the event that I get back there sometime or he, heaven help him, is sent out here.

Our outfit was sent out here in the . . . from . . . several weeks ago. We are cuddled up on a little coral island about a mile and half long and quarter mile wide. We have cocoanut trees galore, some Pandanas, goony (spelling?) birds and, occasionally, an unsuspecting navy man visits us.

If the natives have ever seen a grass skirt, they don't mention it. They like G. I. clothes and want to play baseball and volley ball with our fellows. Very disappointing. As for the practice of medicine, I can't tell you a thing but if you want a chair knocked together out of driftwood and old canvas, let me know. Beach combing can be so restful at times.

Yours,
Carl C. Hanchey,
Major, M. C.

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THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

VOLUME XL

JUNE, 1943-MAY, 1944

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COMMUNIQUE

April 1, 1944

To the Editor:

Sure good to receive your letter and I wish I could attend the state meeting. We always hve so much fun at the meeting. Let's hope it's not too long until the doctors can get back to the States.

Our address keeps changing. Don't guess we will get settled in one place for very long at one time until we get home.

Maybe I will see some of the fellows here in * * *. But you hardly ever meet anyone you know.

We sure enjoy hearing from home.

Yours,
Ulys Jackson, Capt., M. C.

COMMUNIQUE

March 11, 1944.

To the Editor:

I have just received your March issue of Random Thots and your appeal for communications fell on fertile ground and happened to find me not too very busy. You really can't know how greatly your efforts are appreciated, at least by me. All news from home, regardless of how old, is the most welcome thing in any day. And mail-call still is the most eagerly attended time of any day.

I have missed some of the copies that have been sent and it is most probably because I haven't stayed in one place any too long. This is the third theater of operations that I have been in the past year and a half. I have had news occasionally that someone from Arkansas has been in my vicinity, but I have yet to meet a single one of them. In my outfit we have had a grand dental officer from St. Louis who knows Paul Mahoney and Ellery Gay and few others from Arkansas, so we chat often about the good old state.

Since being in . . . I have been greatly pleased to receive several copies of the Arkansas Journal. They were mailed many months ago and are just catching up with me. In your letter of today was the membership card for the Society and I want to thank you very much for sending it. It almost makes me feel like a doctor again. Working in small dispensaries and practicing medicine out of a small emergency kit leaves much to be desired when one remembers X-ray machines and other aids to diagnosis. I have had reason to remember what Dr. G. V. Lewis taught us in school—that a good doctor has all of the facilities of diagnosis in his own senses and that X-ray and lab procedures are only to confirm the physical findings. That has been a small consolation when it has been impossible to dish out the proper medicines.

All of us who have been over a long time are out of touch with the legislative procedures regarding socialized medicine and other controversial subjects. We have had to rely on rumor and occasional mention in letters from home. But from these routes of communication we have had the feeling of growing alarm that all doesn't go too well on the home front along such lines. From the reports the medics aren't doing too much about the situation except talk and it doesn't help us to realize that the men at home are responsible for allowing things to happen. I am not chiding them for inactivity, but I wish they would do something constructive. It would make the outlook a little brighter for the post-

war world. Perhaps in one of your letters you can clarify the situation a little. I, personally, would greatly appreciate it.

Thanks again for the work that you are doing and if I don't write too often it will not be because I don't appreciate your efforts. Good luck to all of you and keep hoping for the end of this mess.

Sincerely,

George R. Steinkamp,
Capt., M. C.

COMMUNIQUE

To the Editor:

A much belated note to express appreciation for sending The Journal and membership card.

Enjoy the personal column of The Journal very much, as it is the only way of keeping up with old friends.

Allan Russell (Pine Bluff) is in . . . ; King (Elaine) is in 54th Gen. Hospital, A.P.O., San Francisco. Have misplaced the number but can get it later if you want it.

As for myself, I've wandered around a bit, but always come back to Fort Riley. Chief of medicine at Station Hospital at present.

Thanks again for The Journal, membership card and "Random Thots."

Sincerely,

F. C. Maguire, Capt., M.C.,
Station Hospital,
Fort Riley, Kansas.

COMMUNIQUE

April 9, 1944

To the Editor:

Received my first edition of The Journal and I'm sure my address was given by a civilian friend of doctor of Little Rock. Every page of news was most welcome. It seems you do well in Random Thots even if no local service papers are being sent.

My army service has been spent at Brooke General Hospital, Fort Sam Houston, Texas; Borden General Hospital, Chickasha, Oklahoma, except for two months at the School of Tropical Medicine, Army Medical Center, Washington, D. C. My present assignment is in * * *.

The above is a short summary of nine very good months in the Army and all the personal news except to add that becoming a father when so remote is a life filled with many (?). I am grateful to the doctors of Little Rock for taking good care of the situation while I'm away.

Anticipating future Journals, Random Thots, and seeing you all in the States.

Sincerely,

Harlan H. Hill, Lt., M. C.

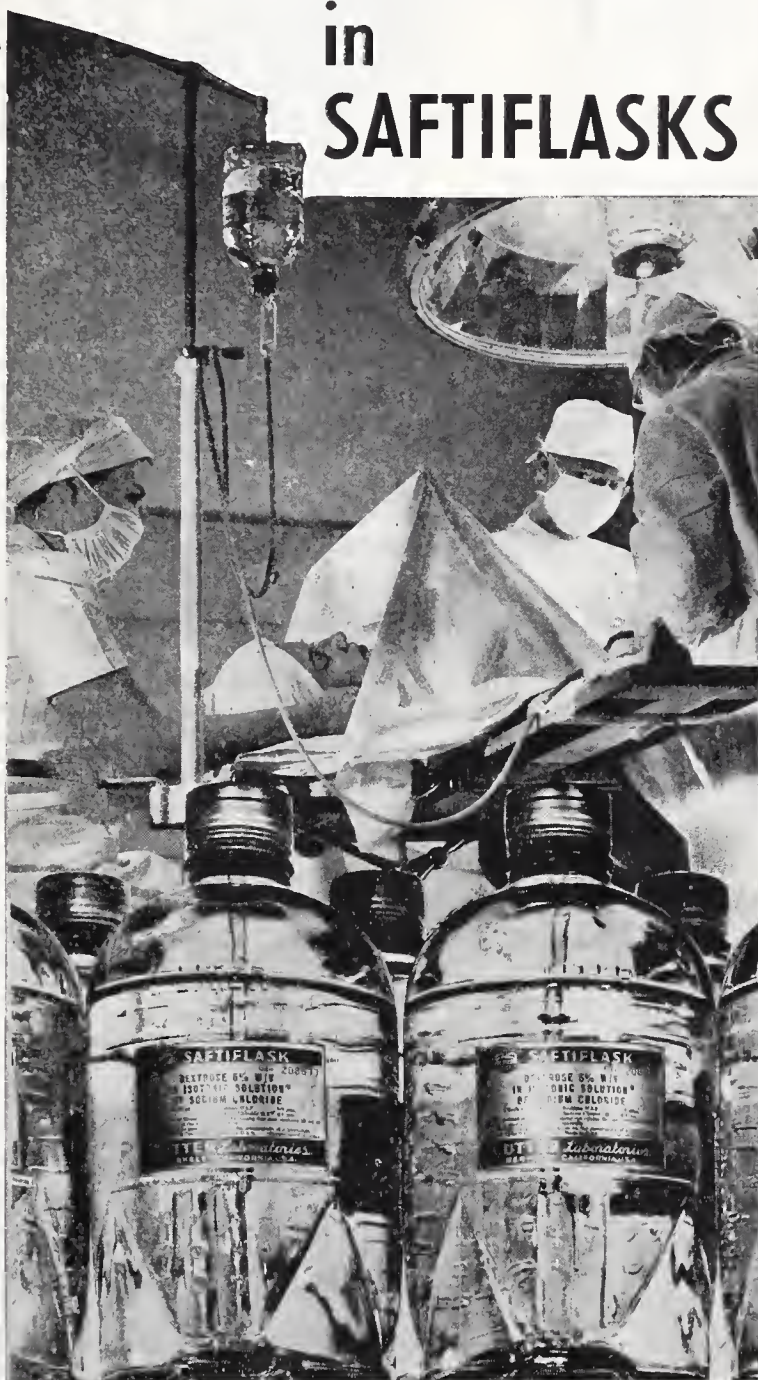
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THE COUNCIL URGES SUPPORT OF JOURNAL ADVERTISERS

COMMUNIQUE

March 18, 1944.

To the Editor:

For some time now I've been getting mail addressed to some nameless soul and since it finally came after many months across many strange countries, it came to me that I might write to you. I apologize for addressing you as I did but you must know that I might easily mistake a dollar bill for tissue paper by now.

The last meeting I attended was in Fort Smith around 1940 and long will I remember the gracious and beautiful women, the red wine and the wisdom that came from the erudite doctors.

Now actually you need not worry about our morale. At the moment, we of the more gypsy type are forming a club to boost your own spirits. It's a wonderful thing to be over here with complete freedom, if one can ignore the few army regulations.

We have had a lot of experiences and our unit has had a column or two in some of the larger papers back in the States. This was not for heroics, though.

I would offer you this constructive criticism: When you write again please send some pin-up girls, also change the salutation, as that word "Greetings" was on another letter we got.

Now my name is Jabez F. Jackson and I'm chief of the medical services in a general hospital. The Jacksons have belonged to your Society since before 1900. However, I had my training, if you wish to dignify it, in other states and had actually been in Arkansas only about two years since I started to shave. One fellow from my home town was in an armored division and he deserves a hell of a lot of credit—Max Hughes.

In all my travels I've never seen a doctor from Arkansas.

Thanks. Cherrio.

Jabez F. Jackson,
Major, M. C.

BOOK REVIEW

Female Endocrinology: By Jacob Hoffman, A.B., M.D., Demonstrator in Gynecology, Jefferson Medical College; Pathologist in Gynecology, Jefferson Hospital; formerly Research Fellow in Endocrinology and Director of the Endocrine Clinic, Gynecological Department, Jefferson Hospital, Philadelphia. 788 pages with 180 illustrations, including some in colors. Philadelphia and London: W. B. Saunders Company, 1944. Price \$10.00.

The composition of the text is excellent and can be easily digested by the reader because of the simplicity of the phrasing.

The chapters devoted to Sterility, The Climacteric and the Menstrual Cycle will prove to be a great aid to the



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general practitioner as he is faced daily with such problems and this book offers many possibilities without being dogmatic.

The author offers treatment, diagnosis and the etiology in many of his chapters that are now fully accepted as proper and routine procedure in endocrine disturbances. He also cautions against the use of certain hormones just because a statement has been made that they are good for a certain symptom.

The section on the male is very short and adds but little to what has already been said and written on this subject.

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Little Rock

President

Arkansas Medical Society

1944-1945

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Vol. XLI LITTLE ROCK, ARKANSAS, JUNE, 1944 No. 1

PRESIDENT'S ADDRESS *

S. J. ALLBRIGHT, M. D.

Searcy

Allow me to take this opportunity to again thank you for the honor of being your President for the past year. This body is, in my estimation, the greatest organization in Arkansas and it is a distinct honor to be chosen to the highest office in the Society. I am indeed grateful.

This has been a very busy year. Not only have we as physicians been called upon to serve more people professionally because of war conditions, but so many advancements have been and are being made in medicine that a physician must needs give more time to their consideration in order that he may keep abreast. It seems rather a long way now from the time I first saw arsenic used in treating syphilis; when each patient was told that one dose of "606" would cure syphilis either active or latent; when it was almost a major operation to give an intravenous injection of any sort; and such a procedure required two physicians, two interns, and two or three nurses; when an incision was made, the vein was transfixed and a canula sometimes larger than the vein was introduced, to our present time when we tell our patients who have syphilis, "You must continue this treatment for 80 weeks then we hope you will be well," and when any competent nurse can give an intravenous either large or small with less ado than bathing a patient's face. I think no other generation has ever seen so much change as we have and it seems as though progress might be just beginning. During such a devastating and terrible war which involves most of the people on the globe one might expect research and development of means of treating the ill to be suspended in favor of war activities, but since this one has begun new remedies have been introduced and have come into common use, the dread word pneumonia has lost much of its power to produce fear among the lay people, gonorrhea is often cured in ten days instead of

six weeks or longer, that more than ninety percent of the wounded on the battlefields of the world are recovering and we hope in the very near future that penicillin will enable us to do something very definite with syphilis as well as many other infections.

There has been a constant progression in the facilities for medical education during this generation. From the time when there were many medical colleges, poorly financed and having various entrance requirements and various attendance requirements, when the faculties were composed of part-time instructors, when our own University of Arkansas School of Medicine was inadequately housed, when it had only one microscope and one X-ray machine that would not work, when most of the patients the students saw were out-patients and a large percent of them were venereal patients, to our present time, when through the efforts of organized medicine there are fewer medical schools, all of which are parts of universities and have many full time instructors, all have hospitals in connection so that students come in bedside contact with various diseases. We all heartily approve of this improvement and realize that students who graduate from the present day medical schools have a distinct advantage yet I some times feel a degree of pity for such students. It seemed that in the old medical school there was so much to learn we could not possibly master enough to pass our examination. Now with all the added machines, laboratory tests and medicine the question arises how can one head contain it?

We are proud of our University of Arkansas School of Medicine. As I have said on other occasions it is an Arkansas School for Arkansas students. By far the greater part of its students are bona fide residents of the state and most of the residents of Arkansas who enter medical school enter this school. No student of this school need apologize because of choosing this school. We are indeed glad it now has Class A rating. I do not know what effect the war program of continuous sessions twelve months each year will have on the future. I also doubt if the government taking over all medical schools has been a

* Presented to the Sixty-Ninth Annual Session, Arkansas Medical Society, Little Rock, April 17, 1944.

marked advancement. No one can foresee the consequences when such a large percent of the graduates from medical schools will be in the armed forces. Nor can anyone see what will be the result when the government discontinues funds for this purpose. I only wish to say in this regard, Lord hasten the time when we learn that Federal money is our money and what we spend must be repaid and that any project into which the Federal government puts money must to some extent be regulated by the Federal government all of which tends to centralization of government and to abrogation of states rights.

When I began the study of medicine an X-ray machine was indeed rare and comparatively few physicians used microscopes. Each physician had his own laboratory, such as it was, there were no technicians, very few specialists and only a few of the boldest were doing surgery and they often in only the direst emergencies. Yet there were some excellent physicians in those days. They used their five senses, they knew anatomy, physiology, therapeutics and clinical symptoms. They made mistakes but we do now sometimes even with all the mechanical improvements at our command. It does not seem amiss to say at this time that we should strive at all times to use the methods they used along with the new ones. In doing this I am sure we would all make fewer mistakes and better serve our people.

Among the most potent drugs of recent introduction is the sulfonamide group. Some of this group have been known for several years but have only recently become generally used in treating infections. We know the sulfonamides are potent for good in fighting a number of infections. We do not know yet what harm might be done by their continued promiscuous use. It is very evident they are more nearly "fool proof" than we at first thought because so many people are taking them promiscuously for every ailment and some are taking them every day as a preventive against disease. I recently saw this item in a camp paper from one of our Naval Stations: "The man who neglects to take his daily sulfa ration now being provided for all the personnel of this station may be depriving himself of protection from an unseen enemy which may well prove more deadly than any German or Jap * * *. The use of sulfadiazine at five (5) Naval Stations with close to 200,000 men being given the drug as a preventive measure resulted in such an amazing decrease in the incidence of certain communicable diseases that wider use of sulfa was considered imperative." I have been afraid and I still am afraid that promiscuous indiscrimi-

nate use of these drugs will lead to a sulfa-fast condition such that if at some future time these patients need these drugs they will not be effective. I believe it is well that we bear this in mind and only prescribe these drugs when indicated for specific conditions.

I wish I knew how to properly pay a tribute of respect to all the physicians who have answered the call to duty and are now in service with our armed forces all over the world. Many of them are from our own state, our close friends, and we miss them at this meeting. They are all making sacrifices and are a part of a machine which is doing a wonderful job. They are doing this without thought of safety to their own bodies or lives, the medical corps and the hospital units are always with the second wave, which is never far behind the first wave, in an invasion. No group of our soldiers while in action is allowed to advance so far as to lose contact with the medical unit. Also many of our medical men in the Navy are in constant danger to life and limb. Occasionally one of them is cited because of some outstanding deed of valor as were our own Dr. Wassell and Dr. Wickard, but many a heroic deed by medical men in the Army and Navy will remain untold and the greater part of recompense these men receive must be the sense of duty performed and the gratification they will have from feeling they have helped save lives by their unselfish efforts. The speed with which wounded on the battle field are reached and cared for is one large reason so many wounded are recovering. We wish all these men the best of luck and may God speed the time when it is over and they may all come home.

This has not been a year for the Legislature to meet in Arkansas and we have not had to watch from that quarter to see that no laws concerning medical matters which would be against the best interests of the people should be passed. However, some proposed Federal laws have given us great concern. The tendency toward centralization in Washington has been so rapid and subtle that we sometimes wonder if our democratic form of government will survive and if we are not about to lose at home what our boys are fighting for overseas. The subtlety of action of these forces is well illustrated in the Emergency Maternal and Child care plan. This plan was not submitted to nor voted upon in Congress until it had already been started and every soldier's family had been notified they were entitled to such services at the expense of the Government. Then Congress was asked for funds to continue the plan. Later when physicians and medical so-

cieties did not approve the plan such a turmoil arose and such criticism developed that the medical profession decided in practically all the states to allow physicians to participate in the plan as the lesser of two evils. Do not be deceived by the word emergency in this title. It is called Emergency Maternal and Child Care. In my opinion the originators of this plan do not intend that it shall stop but rather that it will spread to something bigger.

Much has been said also about the Federal government subsidizing physicians who change locations and move to new places where there is a scarcity of physicians because of war conditions. I know very little about this but I am against it in principle. It appears to me that it is only another straw which shows the wind blowing toward the Federal government managing the medical profession.

The Wagner Bill I shall only mention to condemn. We believe it will not pass this Congress and probably in its present form will never become a law, but it is well that we remain on guard against similar legislation in the future.

Personally I do not believe people suffer for lack of medical attention in Arkansas. Those who need and want medical attention receive it. There may be some grounds for the demands of a change in our system of medical practice. Probably these reasons do not apply to so great an extent in Arkansas as in some other states but as more industries come into our state these conditions may be more apparent. A rumor gives me this illustration. An industrial community with a population of about 7,000 has three resident physicians. The current medical fees in this community before the boom were one dollar for office calls and two dollars for house visits. The physicians decided to get two dollars for office calls and three dollars for house visits. Two months later one physician was sorely disturbed because the other two would not agree to increase the fees to three dollars and five dollars respectively. "The laborer is worthy of his hire," and I believe physicians in Arkansas have always been underpaid but if the physician, surgeon or specialist charges "all the traffic will bear," I believe he is to some extent responsible for the demand for a change in our system.

It is to be hoped that the Council on Medical Services and Public Relations together with the State Committee will be able to give us the answers to these puzzling questions. It may be insurance (voluntary, not compulsory). It may be prepayment plan or a combination of the two. Frankly I have never read a plan that I thought

would care for all the people in a state which depends largely on agriculture as does Arkansas so well as the system we have used all during the past.

In conclusion allow me to say I am very happy indeed to be here and to serve as your presiding officer. This is the sixty-ninth session of the Arkansas Medical Society and I hope and believe this Society will carry the banner of progress and development in matters pertaining to medicine in the future as it has in the past and that each component society and each individual member will strive to see that every eligible physician in Arkansas is a member of our Society.

I thank you.

COMMUNIQUE

May 2, 1944.

To the Editor:

Am writing you a note to tell you how much I have enjoyed "Random Thots" which have reached me by air, sea, and on one occasion, by personal messenger, a very black one.

It has been two and one-half years since I left Warren to report in at Great Lakes. Arrived December 1, 1941, and as soon as they were sure they had me in uniform the war was started without delay. Within a short time I found myself watching the Golden Gate fade out of view astern.

Have been out here for over two years now and have been around a bit but to date have not been fortunate enough to run across anyone from Arkansas. Probably out fishing. Rumor has it some of us will be going back soon but the scuttlebutt spills a lot of stories like that.

Have enjoyed the amusing stories appearing in "Random Thots" and wish I could contribute something of real significance. * * *

Wish you would change my address to the one given above and keep The Journal and "Random Thots" in the mail.

With best wishes, I am

Sincerely,

Charles D. Belcher,

Lt. Comdr., M. C., USNR.

COMING MEDICAL MEETINGS

Ninth Councilor District Medical Society, Harrison, June 7th.

American Medical Association, Chicago, June 12th-16th.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

In cases of tuberculosis where the scales often are weighted to a precariously small degree in favor of the body, the addition of a systemic or local adverse factor may upset the balance disastrously in the direction of the disease. Such commonplace circumstances as an acute respiratory infection or an attack of measles or influenza have been observed repeatedly to be capable of ushering in an unexpected reactivation. Here are presented case records suggesting that the risk of a known tuberculous person's reaction to so simple a procedure as smallpox immunization should not be overlooked. Some of these cases may represent the operation of pure coincidence, but each of them provides the physician with reasons for observing all possible caution.

SMALLPOX VACCINATION AND PULMONARY TUBERCULOSIS

A search of the literature gives little information regarding the possibility of vaccination for smallpox being the causative factor in a subsequent flare-up of latent or active pulmonary tuberculosis. Blacher (1931) has recorded two cases, both in children. In the first of these a boy aged 11, suffering from dystrophia adiposogenitalis, developed a tuberculous meningitis following re-vaccination, and from this Blacher concluded that the vaccination had re-activated a pre-existing tuberculous focus. His second case was that of a girl aged 11, whose skiagram showed a small hard focus in the right upper zone. She was subsequently vaccinated, and ten days later there was fever and X-ray evidence of re-activation of the pulmonary lesion.

Ainger (1937) recorded two further cases where tuberculous meningitis followed immediately on vaccination, and from this he drew the conclusion that either vaccination lowered the powers of resistance, thus paving the way for a fresh infection, or that an inactive lesion already present flared up as a result of the procedure and spread unopposed throughout the lung.

Stone (1931) reported the results following the vaccination of 337 patients at the Robert Koch Hospital, St. Louis. All stages and types of pulmonary tuberculosis were included in Stone's cases, and only one patient showed any definite pulmonary exacerbation, while two others had a temporary increase in the amount of cough and sputum. His view, therefore, was that the presence of pulmonary tuberculosis was not a contra-indication to vaccination.

In the summer of 1942 there was an outbreak

of smallpox in Glasgow, and later in the same year in Edinburgh and Fife. Considerable numbers of the public were vaccinated, and one of us (R. Y. K.) received numerous requests from former patients of the sanatorium for advice as to whether, in view of their previous pulmonary infection, they should undergo vaccination. Those living or working in Glasgow were advised without hesitation to be vaccinated, as it was felt that the results of smallpox would be much more disastrous than any post-vaccinal flare-up in the chest. As far as is known, none of those so advised suffered any ill-effects. Later in the year four cases were admitted to the sanatorium, all of whom gave a history of vaccination followed almost immediately by the appearance of symptoms of pulmonary tuberculosis.

Case Records

Case 1.—Male, aged 28. This man, an engineer by profession, had an excellent medical history and for years had not been off work for a single day. In June, 1942, he applied for a post abroad, and before acceptance he underwent and passed a medical examination. A condition of his appointment was that he must be vaccinated in this country before departure, and this vaccination was duly carried out by his own doctor in July. Four days following the vaccination he had a severe reaction; he felt feverish and his arm was swollen and tender. After a further three days he developed a sharp pain in the left chest, which proved to be the beginning of an acute pleurisy with effusion. The subsequent skiagram revealed bilateral infiltration with cavitation in the left upper zone. This pa-

tient stated most emphatically that prior to vaccination he had felt perfectly well and had been able to do his work, which entailed considerable physical effort, without the slightest inconvenience.

Case 2.—Male, aged 22. This boy gave a history of pulmonary tuberculosis dating from the age of 16, for which he had received sanatorium treatment on several previous occasions, the last being in 1939. Following this he had remained fairly well and had been living quietly at his home for two years, where his main occupation had been fishing. In July, 1942, he was vaccinated and had a severe local reaction with, at the same time, pain in the chest and dyspnea. Radiological examination a few days later showed the presence of a small pleural effusion on the right side together with a fresh area of exudative disease in the mid and lower zones.

Case 3.—Male, aged 20. This boy had been treated in the sanatorium in 1941 for a left pleural effusion, from which he made a completely satisfactory recovery. He was discharged after a six months' stay and spent the spring and summer of 1942 as junior master in a preparatory school. In the autumn he was in business in Edinburgh, still well and free from symptoms. In November, 1942, he was vaccinated. He had very little local reaction but felt generally "ill," his main symptom being lassitude. He did not feel well enough to return to business, and three weeks later, in addition to the lassitude, he developed a slight temperature associated with the appearance of cough and sputum. Tubercle bacilli were present in the latter, and subsequent X-ray examination showed the presence of a recent area of exudative disease in the right upper zone.

Case 4.—Female, aged 19. This girl was working in an emergency hospital as a V.A.D. and was vaccinated along with her colleagues in July, 1942. She had a severe local reaction and was in bed for four days. Subsequently she felt tired, and three weeks later had the misfortune to fall victim to a mild epidemic of glandular fever which attacked some of the hospital staff. She recovered rapidly from the fever but the lassitude previously present persisted, and shortly after she had a sudden hemoptysis. Radiological examination showed scattered infiltration throughout the left upper and mid zones, with commencing cavitation immediately below the clavicle.

Discussion and Summary

In view of the relatively few references to the

association between vaccination and pulmonary tuberculosis which we have been able to find it is felt that these cases should be recorded. It is impossible to draw any definite conclusions from isolated instances such as these, but it would appear that there is sufficient evidence here to justify the assumption that vaccination may cause a flare-up in a latent focus.

Our results are at variance with those reported by Stone, but it should be remembered that his cases were under sanatorium conditions at the time of vaccination, while those we have recorded were engaged in their normal occupations, and therefore no more precautions were taken in their cases than would be taken with the average healthy individual.

The necessity for widespread vaccination of the population will not, we hope, arise again, but should it so happen it would be well to exercise special caution before submitting to vaccination known cases of pulmonary tuberculosis.

Smallpox Vaccination and Pulmonary Tuberculosis, R. Y. Keers, M. D., and P. Steen, M. D., *British Journal of Tuberculosis and Diseases of the Chest*, July-October, 1943.

COMMUNIQUE

April 24, 1944.

To the Editor:

Saw in your letter where I was now a lieutenant-colonel. Wish that it were true. That rumor started when I was moved to another hospital, same size, for a few months. But we are stuck in grade as long as we are in this size hospital. I am now C. O. of the original hospital outfit that I brought overseas. We do considerable tropical medicine, a moderate amount of surgery. I'm the authority on X-ray! Haven't heard from Ross Maynard in some time but he's still at the ** Station Hospital, A.P.O. 630.

It's too hot to think up a smart remark for you and since your recent humor reminds me of T. Duel Brown at a football game, I'll close.

Fount Richardson, Maj., M. C.

COMMUNIQUE

April 24, 1944.

To the Editor:

Thanks for sending us the letters and The Journal. We enjoy them. After two years in the Aleutians, we're now in the States and assigned to Camp Shelby, Mississippi.

Change my address to the one on the envelope. Capt. R. F. Hyatt will be at the same place.

Thanks,

Lewis Hyatt, Capt., M. C.

THE JOURNAL

OF THE

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W. R. BROOKSHER, M. D., Editor

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EDITORIAL

OUR PRESIDENT

Joseph Franklin Shuffield, installed as president of the Arkansas Medical Society, April 18, 1944, was born in Nashville, Arkansas, in 1892, attended the University of Arkansas for pre-medical work, and graduated from Tulane University of Louisiana in 1923. In addition to internships served at the Baptist State and Missouri Pacific Hospitals in Little Rock, he has had special post-graduate work in plastic surgery in St. Louis, in bone and joint surgery at Harvard University and Massachusetts General Hospital, and in orthopedics at Tulane University, the Campbell Clinic and at the Missouri Baptist Hospital, St. Louis. At this time he is associate professor of orthopedics at the University of Arkansas School of Medicine; chief of orthopedics, Baptist State Hospital; staff member, St. Vincent's Infirmary and Arkansas Children's Hospitals; member of board of directors, Arkansas Children's Hospital; president, State Board of Nursing Examiners; chairman of the Little Rock Board of Health; member of the Arkansas Nursing Council for War Service; instructor in anat-

omy and orthopedics at Baptist State Hospital, and chairman of the fracture committee for Arkansas of the American College of Surgeons. He is a Fellow of the American Medical Association and of the American College of Surgeons, a member of the Pulaski County Medical Society and of the Southern Medical Association, and in the Masonic bodies he is a member of the York rites and a Shriner. He is a past-president of the Pulaski County Medical Society, a member of the Little Rock Chamber of Commerce, a member and past-president of the Little Rock Lions Club and a former commissioner of the Arkansas State Game and Fish Commission. His service in the Arkansas Medical Society has been long and earnest, having served as a delegate for several terms, as councilor, but with greatest distinction and credit as chairman of the society's committee on medical legislation. In this capacity he has freely given of time and effort in promoting and advancing the cause of organized medicine in state legislative circles and the society owes much to him for maintenance of the ideals of the medical profession threatened by vicious legislation.

There is little The Journal can say in the way of praise of President Shuffield. Every member of the society knows of his interest and enthusiasm, of his eagerness and willingness for self-sacrifice in the cause of the medical profession. There can be no greater praise than the esteem and respect in which the entire membership regards its president for 1944-1945. With his demonstrated desires for the advancement of the society and with the willing co-operation of the membership, there can be no doubt but that 1944-1945 will be a year of history in the Arkansas Medical Society.

CIVILIAN SUPPLY OF PENICILLIN

Production of penicillin has progressed to the extent that a limited supply has been made available to the civilian population. Distribution of this allotment over the amounts required will be through hospital depots. In Arkansas, the following hospitals have been designated:
Fort Smith—St. Edwards Mercy Hospital.
Hot Springs National Park—Leo N. Levi Memorial Hospital.

Jonesboro—St. Bernard's Hospital.

Little Rock—Baptist State Hospital, St. Vincent's Infirmary, University Hospital.

Pine Bluff—Davis Hospital.

Texarkana—St. Louis Southwestern Hospital.

The War Production Board which controls the

manufacture and distribution of all penicillin, has established the Office of Civilian Penicillin Distribution. It is the function of this office to handle all details of the distribution of the civilian allotment and to endeavor to insure insofar as possible an adequate and equitable distribution of penicillin throughout the country.

Each penicillin hospital depot has received a quota under which they will be permitted to purchase a quantity of penicillin for their own requirements and to act as depots for hospitals in the vicinity which are not on the initial list. Should a hospital not on the designated list be unable to purchase penicillin from the designated hospital in its area, such a hospital should communicate with the Director, Office of Civilian Penicillin Distribution, 226 West Jackson Boulevard, Chicago 6, Illinois, who will endeavor to provide the penicillin so requested.

The War Production Board has directed that each depot hospital and hospitals not so designated shall use the material only in accordance with the instructions and recommendations issued by the Medical Research Committee of the Office of Scientific Research and Development and the Committee on Chemotherapy of the National Research Council. Copies of this report ("Penicillin: The Indications, Contra-Indications, Mode of Administration and Dosage"—Report "F") are available to any physician free on request from the Office of Civilian Penicillin Distribution, Chicago.

This report states:

"Based upon the experience gained in the past year with penicillin therapy, it has been found that penicillin is the best therapeutic agent available for the treatment of certain conditions, as follows:

Group I Indications

1. All staphylococcal infections with and without bacteremia:

Acute osteomyelitis
Carbuncles—soft tissue abscesses
Meningitis
Cavernous or lateral sinus thrombosis
Pneumonia—empyema
Carbuncle of kidney
Wound infections

2. All cases of clostridial infections:

Gas gangrene
Malignant edema

3. All hemolytic streptococcal infections with bacteremia and all serious local infections:

Cellulitis
Mastoiditis with intra-cranial complications, i. e., meningitis, sinus thrombosis, etc.
Pneumonia and empyema
Puerperal sepsis
Peritonitis

4. All anaerobic streptococcal infections:

Puerperal sepsis

5. All pneumococcal infections of

Meninges

Pleura

Endocardium

All cases of sulfonamide-resistant pneumococcal pneumonia

6. All gonococcal infections complicated by

Arthritis

Ophthalmia

Endocarditis

Peritonitis

Epididymitis

Also all cases of sulfonamide-resistant gonorrhea

Indications in Group II

Penicillin has also been found to be an effective agent in the following diseases but its position has not been definitely defined:

1. Syphilis

2. Actinomycosis

3. Bacterial endocarditis

Conditions in Group III of Questionable Value

Penicillin is of questionable value in mixed infections of the peritoneum and liver in which the predominating organism is of the gram negative flora—i. e.:

1. Ruptured appendix

2. Liver abscesses

3. Urinary tract infections

4. It is also of questionable value in rat bite fever due to streptobacillus moniliformis

Group IV Conditions Contra-Indicated

Penicillin is contra-indicated in the following cases because it is ineffective:

1. All gram negative bacillary infections:

Typhoid—Para-typhoid

Dysentery

E. Coli

H. influenza

B. Proteus

B. Pyocyaneus

Br. melitensis (undulant fever)

Tularemia

B. Friedlanders

2. Tuberculosis

3. Toxoplasmosis

4. Histoplasmosis

5. Acute rheumatic fever

6. Lupus erythematosus diffuse

7. Infectious mononucleosis

8. Pemphigus

9. Hodgkin's disease

10. Acute and chronic leukemia

11. Ulcerative colitis

12. Coccidiomycosis

13. Malaria

14. Poliomyelitis

15. Blastomycosis

16. Non-specific iritis and uveitis

17. Moniliasis

Treatment of Infections with Penicillin

The recommendations put forth in Dr. Keefer's report, based on the wide experience gained under varied conditions of use and purpose, follow:

Method of Preparing Penicillin for Treatment

Penicillin is supplied in ampoules of different sizes—25,000 units and 100,000 units each. Inasmuch as penicillin is extremely soluble, it may be dissolved in small amounts of sterile, distilled pyrogen-free water, or in sterile, normal saline solution. When large unit sizes are being used in hospitals, the contents of the ampoule should be dissolved in water or saline so that the final

concentration is 5,000 units per cubic centimeter. This solution should be stored under aseptic precautions in the ice box, and made up freshly every day. Solutions for local or parenteral use may be diluted further, depending upon the concentration desired.

A. For intravenous injection

1. The dry powder may be dissolved in sterile physiological salt solution in concentrations of 1,000-5,000 units per cc. for direct injection through a syringe.

2. The dry powder may be dissolved in sterile saline or 5 per cent glucose solution in lower dilution (25-50 units per cc.) for constant intravenous therapy.

B. For intramuscular injection

1. The total volume of individual injections should be small, i.e., 5,000 units per cc. of physiological saline.

C. For topical application

1. The powdered form of the sodium salt is irritating to wound surfaces and should not be used.

2. Solutions in physiological salt solution with a concentration of 250 units per cc. are satisfactory. For resistant or more intense infections this concentration may be increased to 500 units per cc.

Methods of Administration of Penicillin

There are three common methods of administering penicillin—intravenous, intramuscular and topical. Subcutaneous injections are likely to be painful and should be avoided.

Repeated intramuscular injections may be tolerated less well than repeated or constant intravenous injections. In many cases, however, the intramuscular route may be the one of choice.

In the treatment of meningitis, empyema, and surface burns of limited extent, penicillin should be used topically, that is, injected directly into the subarachnoid space, into the pleural cavity, or applied locally in solution containing 250 units per cc.

Dosage

The dosage of penicillin will vary from one patient to another depending on the type and severity of infection. In our experience recovery has followed in many serious infections following 40,000 to 50,000 Oxford units a day, in others 100,000 to 120,000 or even more is necessary. The objective in every case is to bring the infection under control as quickly as possible. The following recommendations are made at the present time with a full realization that revisions may be necessary as experience accumulates.

It is well to remember that penicillin is excreted rapidly in the urine so that following a single injection it is often impossible to detect it in the blood for a period longer than 2 to 4 hours. It is well, therefore, to use repeated intramuscular or intravenous injections every 3 or 4 hours, or to administer it as a continuous infusion.

A. In serious infections with or without bacteremia an initial dose of 15,000 or 20,000 Oxford units with continuing dosage as

1. Constant intravenous injection of normal saline solution containing penicillin so that 2,000 to 5,000 Oxford units are delivered every hour, making a total of 48,000 to 120,000 units in a 24-hour period. One-half the total daily dose may be dissolved in a liter of normal saline solution and allowed to drip at the rate of 30 to 40 drops per minute.

2. If continuous intravenous drip is undesirable, then 10,000 to 20,000 units may be injected intramuscularly every 3 or 4 hours.

3. After the temperature has returned to normal the penicillin may be stopped and the course of the disease followed carefully.

B. In chronically infected compound injuries, osteomyelitis, etc., the dosage schedule should be 5,000 units every two hours or 10,000 units every four hours parenterally with local treatment as indicated. This dosage schedule may have to be increased, depending upon the seriousness of the infection, and response to treatment.

C. Sulfonamide-resistant gonorrhea

1. 10,000 units every 3 hours intramuscularly or intravenously for 10 doses. It is not likely that the same effect may be obtained with 20,000 units every 3 hours for 5 doses. The minimum dosage has not been worked out completely. The results of treatment should be controlled by culture of exudate.

D. Empyema

1. Penicillin in normal physiological saline solution should be injected directly into the empyema cavity after aspiration of pus or fluid. This should be done once or twice daily, using 30,000 or 40,000 units depending upon the size of the cavity, type of infection and number of organisms. Penicillin solutions should not be used for irrigation. It requires at least 6 to 8 hours for a maximum effect of penicillin.

E. Meningitis

1. Penicillin does not penetrate the subarachnoid space in appreciable amounts, so that it is necessary to inject penicillin into the subarachnoid space or intracisternally in order to produce the desired effect. Ten thousand units diluted in physiological saline solution in a concentration of 1,000 units per cc. should be injected once or twice daily, depending upon the clinical course and the presence of organisms.

* * *

The above dosage schedules may require revision as increased experience is obtained. In many cases studied by accredited investigators, the above schedule has proved to be adequate.

Conclusion

The Office of Civilian Penicillin Distribution, War Production Board requests medical practitioners employing penicillin to carefully observe the recommendations stated above as to indications, contra-indications, mode of administration and dosage in order to gain the maximum value and advantage from this new medicinal agent.

EDITORIAL COMMENT

ADDRESSES OF MEMBERS IN SERVICE

The Journal is frequently asked why it does not publish the addresses of members now in service overseas. The answer lies in censorship regulations. A recent relaxation permits the publication of A.P.O. numbers but letters so addressed are unlikely to reach their final destination and for that reason it does not seem advisable to publish them. The Journal maintains as complete a list as is possible of all members now in service whether overseas or in the United States and will be glad of the opportunity to forward all letters for our members in service. A casual reading of the letters received from our members and published in The Journal will show how glad they are to hear from home. Surely we can do no less than to write often to colleagues and friends away in service.

ADDRESSES WANTED

The Journal has exhausted all sources known to obtain the present military addresses of the following members. It is felt that some reader may know where the desired information may be obtained. Such help will be appreciated.

Lt. Glen G. Hairston, Prescott.
Capt. J. W. Burnett, Texarkana.
Lt. John P. Eaton, Little Rock.
Lt. Thos. L. Adair, Searcy.

PROCEEDINGS OF SOCIETIES

The Craighead-Poinsett County Medical Society met in dinner session at Jonesboro May 8th and received reports from the state meeting. James Blankenship read the prize-winning essay, "American Medicine at the Cross-Roads." The society voted its thanks to the Pulaski County Medical Society for the entertainment at the recent state meeting.

J. H. McCurry, Cashier.

The Benton County Medical Society met in dinner session at Siloam Springs May 11th for a discussion of the recent state medical meeting and case report presentations.

Geo. M. Love, Secretary.

The Sebastian County Medical Society was addressed May 9th by Jos. F. Shuffield, Little Rock, on "The Obligations of the Medical Profession."

D. W. Goldstein, Secretary.

PERSONALS AND NEWS ITEMS

BORN—To Captain and Mrs. Harlan H. Hill, Little Rock, a boy, George Henry, on March 23rd.

Capt. Vincent Mazzanti, Little Rock, is now stationed with Med. Detach., 383rd Inf., Camp San Luis Obispo, California.

Charles D. Belcher, Warren, now stationed overseas, has been promoted to lieutenant-commander.

Maj. Ellery C. Gay, Little Rock, is recovering in an overseas hospital from injuries sustained March 19th by the explosion of an enemy bomb in a hospital tent where he was working.

"A Retriever" by S. J. Wolferman, Fort

Smith, appeared in the April issue of "The Journal of Bone and Joint Surgery."

O. C. Melson, Little Rock, addressed the recent annual session of the Mississippi State Medical Association at Jackson on "Hypertension."

Irving J. Spitzberg, Little Rock, recently took postgraduate work at Tulane University.

Lt. Leslie G. Holt, Little Rock, is now stationed at Med. Detach., Reception Center, Fort Dix, New Jersey.

Harlan H. Hill, Little Rock, now stationed at Borden General Hospital, Chickasha, Oklahoma, has been promoted to captain.

R. H. Willett recently addressed the Jonesboro High School student body on "Prevention and Control of Cancer."

Pearl Waddell, Fort Smith, spent a recent vacation in Georgia.

Capt. R. E. Smallwood, Hot Springs National Park, is now on duty in the office of the surgeon general, United States Army, Washington.

A. C. Curtis, Little Rock, attended the joint sessions of the Mississippi Valley Tuberculosis Association, the National Tuberculosis Association and the Trudeau Society in Chicago during May.

Lt. Phillip T. Cullen, Little Rock, is now stationed at Kelly Field, Texas.

Capt. C. L. and Robert F. Hyatt, who have been on duty in the Aleutians, are now stationed at Camp Shelby, Mississippi.

"The Pelvoscopic Method of Uterine Suspension" by Maj. W. B. Harrell, Little Rock, appeared in The American Journal of Surgery, November, 1943, issue.

Vann C. Binns, Monticello, now stationed overseas, has been promoted to major.

Thos. P. Foltz, Fort Smith, now on duty at the Induction Station, Little Rock, has been promoted to lieutenant-commander.

Maj. Chas. H. Finney, Fort Smith, has re-

turned from overseas service and is now stationed at Birmingham General Hospital, Van Nuys, California.

Capt. William H. Calaway, Batesville, has been transferred to the Station Hospital, A.A.F., Santa Maria, California.

A. C. Shipp, Little Rock, attended the joint sessions of the Mississippi Valley Tuberculosis Association, the Trudeau Society and the National Tuberculosis Association in Chicago during May.

O. C. Melson, Little Rock, has been appointed councilor from Arkansas to the Southern Medical Association.

Capt. Chas. P. Wickard, Little Rock, has been awarded the Silver Star for gallantry in action in the South Pacific.

J. B. Wells has moved from Scott to Little Rock.

Maj. C. H. Reagan, Marked Tree, who was stationed in the Aleutians for over two years, has been assigned to Camp Chaffee, Arkansas.

Capt. Ben H. Pride, Fort Smith, has been assigned to Camp Chaffee, Arkansas.

An Office of Information in Washington, D. C., was opened on April 3 by the Council of Medical Service and Public Relations of the American Medical Association. It is located in suite, 900, Columbia Medical Building, 1835 I Street, Northwest.

Capt. John B. Elders, Walnut Ridge, has been assigned to the 525 Clr. Co. (Sep), at Camp Van Dorn, Mississippi.

A. C. Kolb, Little Rock, attended the Centennial Session of the American Psychiatric Association during May.

Maj. John W. Smith, Little Rock, who has been overseas, is now assigned to the Air Forces Redistribution Center, Miami, Florida.

Lt. Phillip T. Cullen, Little Rock, is now stationed with the 56th A.D.G., Oklahoma City, Oklahoma.

OBITUARY

WILLIAM TURNOR WOOTTON, age 67, Hot Springs National Park, died in a St. Louis hospital May 2nd. Born at Pollsville, Maryland, April 12, 1878, he graduated from the University of Maryland College of Medicine in 1899 and immediately entered service in the Army Medical Corps for the Spanish-American War and the Filipino insurrection. Locating in Hot Springs in 1902, he married Miss Emma Whittington, who survives him, in 1904. He engaged in active practice of medicine until his retirement in 1938. He had served as president of the Garland County Medical Society, as president of the Arkansas Medical Society and was president of the Southern Medical Association at the time of his death. He had previously served as councilor of that organization. He was a charter member and past-president of the Hot Springs Kiwanis Club and had been a deacon of the First Presbyterian Church for 35 years. He was a member of the Order of the Carabao. With the assistance of the late Dr. C. T. Drennen, he was instrumental in passage of the Gant law which greatly helped in the advancement of Hot Springs National Park as a spa where scientific and ethical medical service could be obtained. In addition to Mrs. Wootton, he is survived by two daughters, Mrs. Euclid M. Smith, whose husband, Lt. Col. Euclid M. Smith, was associated with Dr. Wootton in practice prior to entrance into military service, and Mrs. Lawrence Westbrook; three brothers, and one sister.

MARTIN L. CANTRELL, age 39 years, Marked Tree, died April 19th after an illness of four months. Born in Marked Tree, April 8, 1905, he attended schools there and later attended Jonesboro College and the University of Arkansas. His medical education was obtained at the University of Tennessee College of Medicine from which he graduated in 1931. Upon graduation, he served an internship at the Baptist Hospital, Memphis, and then entered the Army Medical Corps for one year. Entering private practice, he first located at Luxora, but moved to Marked Tree two years later. During high school days he was a well-known athlete and broke the state discus record in 1923. He had served the Craighead-Poinsett County Medical Society as secretary for two terms.

RANDOM THOUGHTS OF THE SECRETARY

April 26th. Political forecasting: It looks like Bob Robins in a walk for Democratic National Committeeman.

April 27th. On this day Everett Moulton displays skill in veterinary obstetrics improving the maternal mortality at Eberle's farm by the lives of two calves saved and becoming, furthermore, entitled to distinction for a contribution to the war effort in the ultimate production of food.

April 30th. The seizure of Montgomery Ward by the President calls for clear and earnest thinking on the part of Americans. There is every need that the extent of the powers a president holds in war time should be fully explored by Congress and the full story should be given to the public. It is difficult to rationalize this action with our vaunted American system. Medicine needs well to ponder its reception by governmental authority at a time like this. If out of a controversy as this one there should come a more wide-spread acceptance of "Four Freedoms" here at home, the gain would be well worth the disturbance.

May 3rd. Comes Jack Kennedy from Prescott who wants to be a medical officer and leave procurement and assignment to worry with another area of medical shortage. Yet we are convinced and the papers start their way through the mill.

May 8th. Today comes a copy of "Yank Down Under" from Mobley who is the second member to listen to our plea for old service magazines to sustain the morale of the home front.

May 9th. President Shuffield talks to the county society giving suggestions for the improvement of public relations in a fast-moving world and in the after-glow the discussion is of varied affairs, medical and otherwise. As the new president, we deem it expedient to acquaint him with some of the travel problems of visiting district and county societies this early in his term of office, so place him aboard the Rocket at Booneville at two in the morning, giving him the solace of his thoughts into Little Rock at five o'clock.

May 11th. Hearsay tells us that Merle Woods is flying a Piper Cub over the countryside in a foreign land these days. We are willing to wager that this plane is patched with adhesive the same as was his locally based aircraft in days gone by.

COMMUNIQUE

April 28, 1944.

To the Editor:

Your March "Random Thots" just reached me after following me around the world. Thought I'd better let you know my new address. I returned to this country December 3rd, coming the Pacific route with a stop-over in Australia. Since I went over the Atlantic route, this means that I completed the trip around this old world of ours with at least a short stay on every continent except Europe.

I had a 30-day leave at home in Atchison, Kansas, and certainly enjoyed every minute of it. It is very wonderful to be back with the family again. They are out here with me now,

living at 14802 Gilmore St., Van Nuys, California. We rented a furnished five-room bungalow and left most of our junk back in Kansas. Bob is going to Junior High School, making lots of wood stuff in manual training, playing a cornet in the school band, and growing like a weed. We like California pretty well, but think the climate, etc., is mostly Chamber of Commerce propaganda.

Was glad to learn that Shippey is back in this country, and hope he likes Topeka. I saw him in the middle of * * * on one of my malaria inspection trips. I know he is just as glad to be back as I am.

This hospital is a * * * bed affair, sprawled all over this part of the country. I was chief of the Officer Section for a while, but recently got a new job, that of Admission and Disposition Officer. We admitted * * * new patients yesterday, so you can see they keep me busy enough to stay out of mischief. Most of our patients come from the various * * * theaters and offer very interesting professional problems.

Please give my regards to your family and all of the gang at the clinic and hospital. We would certainly like to see all of our Fort Smith friends again and know that those Arkansas Ozarks will soon be very beautiful.

Write when you can and give me all the dirt.

Cordially yours,

Charley Finney, Maj., M. C.

COMMUNIQUE

April 20, 1944.

To the Editor:

Just received your "Service Thots" as of March and was indeed glad to get it. However, missed the usual joke. Looks like someone tore off a piece that was really fine. It would be wonderful if you could come back home * * *

Am sitting here in my tent, have my candle and nibbling some of the hard biscuit from a C ration. Will go for the candy part next. Somehow the food here does not have the value as it does at home for we all eat more and stay hungry the remainder of the time.

Everything is quiet here at the present; have not had to run jump in a hole in quite a while now. That is agreeable with all of us.

Definitely, the cross-wise business is no go, so my men tell me.

Keep the good work going.

Always,

Hunter A. Causey, Capt., M. C.

PROCEEDINGS OF THE SIXTY-NINTH ANNUAL SESSION

ARKANSAS MEDICAL SOCIETY

MARION HOTEL, LITTLE ROCK, ARKANSAS

April 17th and 18th, 1944

FIRST SESSION, HOUSE OF DELEGATES

April 17, 1944

The meeting was called to order by President Allbright at 9:30 A. M.

The Credentials Committee (S. W. Douglas and J. O. Rush) reported that the credentials of the delegates present had been examined, found correct, and that a quorum was present.

The secretary called the roll of the house.

The following delegates and county society members seated as delegates by the action of the House of Delegates were present:

ASHLEY—M. C. Crandall; BENTON—C. S. Wilson; BOONE—D. L. Owens; BRADLEY—W. J. Hunt; CARROLL—J. F. John; CHICOT—J. H. Burge; CLAY—F. H. Jones; COLUMBIA—J. H. Wilson; CRAIGHEAD-POINSETT—L. H. McDaniel, J. H. McCurry; CRAWFORD—S. D. Kirkland; CRITTENDEN—B. M. Stevenson; CROSS—R. Longest; DESHA—H. T. Smith; DREW—J. S. Wilson; FAULKNER—C. A. Archer, Jr.; GARLAND—John Proctor, G. C. Coffey; HOT SPRING—W. G. Hodges; HOWARD-PIKE—M. D. Duncan; INDEPENDENCE—W. J. Ketz; JOHNSON—Earle H. Hunt; LAWRENCE—J. C. Land; LINCOLN—C. W. Dixon; LITTLE RIVER—Norman Peacock; LONOKE—S. S. Beaty; MILLER—B. C. Middleton; MONROE—E. D. McKnight; MONTGOMERY—J. B. Steuart; NEVADA—A. S. Buchanan; OUACHITA—J. P. Clemens; PHILLIPS—J. W. Butts; POLK—B. H. Hawkins; POPE-YELL—Robert Hood; PRAIRIE—J. C. Gilliam; PULASKI—Hoyt R. Allen, Fred W. Harris, C. A. Rosenbaum, C. M. Brooks, Paul Fulmer, R. M. Blakely, J. A. Summers, A. C. Shipp; SALINE—L. J. Harrell; SEBASTIAN—I. F. Jones, S. J. Wolferman; SEVIER—R. C. Dickinson; UNION—D. E. White, A. D. Cathey; WASHINGTON—Ruth Ellis Lesh, and WHITE—M. C. Hawkins, Jr.

Other members of the House of Delegates present were: President Allbright; President-Elect Shuffield; Vice Presidents J. C. Land, Bryce Cummins; Councilors L. T. Evans, J. O. Rush, S. W. Douglas, S. A. Thompson, C. E. Kitchens, H. King Wade, M. J. Kilbury, J. G. Gladden and Clyde McNeil; Treasurer P. L. Mahoney; Past-Presidents E. E. Barlow, A. S.

Buchanan, Geo. B. Fletcher, L. J. Kosminsky, M. E. McCaskill, M. L. Norwood, D. A. Rhinehart, S. J. Wolferman and W. T. Wootton, and Secretary Brooksher. President Allbright appointed Earle H. Hunt, A. S. Buchanan and C. A. Archer as Reference Committee.

By motion (Hunt-Shipp) the minutes of the 68th annual session as printed in the June, 1943, issue of The Journal of the Arkansas Medical Society were adopted as correct.

Vice-President J. C. Land took the chair.

President Allbright delivered the President's Annual Address to the House of Delegates.

PRESIDENT'S ADDRESS TO THE HOUSE OF DELEGATES

First, let me say I appreciate, more than I have words to express, the honor you have conferred upon me by allowing me to serve as your president. It has been one of the happiest years of my life and I shall always treasure it in memory. The whole-hearted, willing cooperation of each individual member, the members of the various committees, the officers, the past-presidents, the council, and especially our esteemed secretary, has made it indeed a pleasure to serve as your president.

In this world crisis when all of us are more busy than usual it has not seemed expedient that I attend every county and district society though I should have liked very much to have done so. However, in my contacts in all parts of the state I have been impressed with the earnestness and determination to carry on at whatever sacrifice of personal welfare or physical wellbeing by the physicians. I have also been impressed with the interests manifested by physicians in questions pertaining to the future medical care of the people. Such questions as the proposed "Wagner Bill" and "Obstetrical Care for Soldiers' Wives" have never failed to arouse much interest and heated discussion. This is not a selfish interest. I am sure if physicians felt that the people of our country would receive better medical care under some government-regulated system, they would all favor it even though it meant more personal hardships for our

profession. While on this subject I think it would be well to call your attention to an editorial in the March issue of our own Journal. The editor cautions us against being over-optimistic and not to consider that the Wagner Bill is already defeated. Just now there seems a good probability that it will not pass but the sponsors of this bill are still busy and if we cease our efforts some compromise measure might be passed.

As you are all aware, the government plan for the obstetrical care of the wives and the pediatric care of infants of those in our armed forces is not approved by this society. The matter is left to the discretion of the individual physician. He may or may not, as he chooses, participate in the program. As in all other attempts of government medicine, there is much dissatisfaction for both the physician and patient. However, due to the vast amount of publicity given this plan and the adverse criticism which would develop against the medical profession should we take definite stand in opposition to the plan, I think we should leave the question as it is and allow those who so desire, to participate in the program.

I think the National Physicians Committee for the Extension of Medical Service has done, and continues to do, a great work in molding public opinion against national legislation which would be against our interests and the interests of the public and believe such an organization merits our financial support. In July, 1943, this committee employed the largest opinion research group in the country to make an independent unbiased study of people's opinions concerning medical care. This report shows some rather startling figures. Only 21% had heard of a plan to increase Social Security tax and furnish medical and hospital care. After explanation, 32% favored government medicine, but 50% of that number were not in favor of it if the Social Security tax had to be increased to 6%. This is only one of the many activities of this committee.

More recently the Council on Medical Service and Public Relations has come into existence, and at the request of this council, a committee has been appointed in the state. We are expecting this council to formulate plans and suggest changes in our system of medical practice rather than allow visionary social workers and self-seeking politicians to do so. We have had a few tastes of "government in medical practice" in FERA, WPA, NYA, FSA, and now emergency maternal and infant care, and in each

instance there has been much dissatisfaction among the patients as well as the physicians.

At the last meeting of the House of Delegates, the president was ordered to appoint an Advisory Committee with whom the governor of our state, or other legally constituted authorities, might confer upon matters of interest to the medical profession. Such a committee has been appointed and I think it would be well to continue this committee with whatever changes in its personnel the incoming president sees fit to make.

In each of the reports which I read to the House of Delegates during my tenure in office as secretary of The State Medical Board of The Arkansas Medical Society, I advocated an annual registration law. Such a law has now been in effect for four years. I realize there is some opposition to this law, and I am of the opinion this opposition would be much less and would be more easily dealt with if, as both my immediate predecessors have suggested, a permanent office were maintained in the Capitol with a full-time employee in charge of the records. There are still some violations of the medical laws in the state aside from the several who have not paid the registration fee. According to the last directory (A.M.A.) there are 1,806 physicians in Arkansas. The report of the secretary of our examining board last year says there are 1,345 whom they have been able to locate. The eclectic's printed directory accounts for 200. Where are the rest? The members of our medical examining board are busy men who must serve their people and do not have the necessary time to ferret this out. And until such a time as someone can devote his entire time to this matter, it will not be solved. Because of the very nature of these cases this employee should have some knowledge of law and it seems to me it would be possible for this employee to also serve this society as legal adviser and that this society should contribute to the expenses of such office to the extent we now pay our attorney.

Some of the members of the Eclectic Medical Association, I understand, favor a composite examining board. There was a time a few years ago when this society wanted very much to have such a board. It seems to me there are some very good reasons for it now. It is my opinion this should only include the regulars and eclectics and have no effect on the Basic Science Board and other boards. I would like to suggest that the Legislative Committee of this society

be instructed to meet with the Legislative Committee of the Eclectic Medical Association in an effort to have such a law enacted by the next session of the Legislature.

As your president, I have been asked to serve as a member of the Executive Committee of the Arkansas Blood Plasma Program. The establishment of this plan was made possible by gifts or grants from a large mercantile concern and a prominent fraternal organization. Their only interest in the plan is to serve the people of Arkansas. The plant for processing blood plasma has been in operation for some time but has not been able to run at capacity production for lack of donors and personnel. This has been corrected by further grants and the plan is being so perfected that blood may be collected in various parts of the state and dried plasma may be available for use by any physician in the state when his patients need it. The plan has been approved by representatives of the American Red Cross. After careful perusal of the plan these men said: "It is the best we have seen and we would not be surprised if other states follow Arkansas' plan in this movement."

A refrigerator truck, which will be accompanied by a registered nurse who is capable of checking hemoglobin and blood pressure and taking the blood, if local physicians desire, will come to your county to collect blood when your county committee, consisting of your county judge, a physician, a representative of your county health unit, a member of the Masonic lodge and probably a representative of the Red Cross, notifies the Little Rock office that donors are ready. When blood is taken, plasma will be left in that community in charge of such person as the county committee may designate for use by any physician. The physician or the county committee shall say whether or not this patient is able to pay. If he is able, a fee of \$5 or \$10 will be expected; if he is not, he is to have the plasma in required quantity gratis. I may say the plan is meeting enthusiastic reception by physicians and others as well and since this is the first time it has been brought before the society I would like to see the House of Delegates approve the plan. Two things are asked of physicians, 1st, approval and assistance if necessary in obtaining donors and taking blood; 2nd, use the plasma, if and when your patients need it. Already the bank has been called upon in emergency. Fifty units were sent to Camp Robinson to be used on soldiers after a bomb explosion and 200 units were sent to the ordnance plant at Pine Bluff.

This is my message to you today.

I thank you.

President Allbright returned to the chair and the committees of the society reported in order, each report being referred to the Reference Committee.

SCIENTIFIC WORK

M. C. HAWKINS, JR., Chairman

Your committee has arranged the program that you now have before you. We hope you like and find it instructive and entertaining.

HEALTH AND PUBLIC INSTRUCTION

W. B. GRAYSON, Chairman

The Committee on Health and Public Instruction desires to make its report on health conditions in Arkansas during the past year.

There was no unusual incidence of any particular disease with the exception of meningococcus meningitis and possibly poliomyelitis. 127 cases of meningitis occurred. This equals exactly the total for the previous five years. 84 of these cases were in members of the armed forces, three of whom died, and 43 in the civilian population, 6 of whom died. During the year 77 cases of poliomyelitis were reported as compared to 152 cases in 1942 and 344 cases in 1937, the year of greatest incidence.

The following diseases show a decrease in the number reported in 1943 as compared to 1942: Diphtheria, Malaria, Measles, Mumps, Pellagra, Typhoid Fever, Cancer, Amoebic Dysentery.

Those diseases showing an increase in 1943 over 1942 are: German Measles, Trachoma, Whooping Cough, Influenza, Bacillary Dysentery, Gonorrhea, Chancroid, and Pneumonia.

Six year tabulation of births and deaths with rates per thousand:

	1943	Previous 5 years
Births	22.1	20.31
Deaths (Crude Rate)	8.2	8.62
Tuberculosis (All Forms)47	.54
Infant Mortality	35.6	44.84

Venereal Disease Control

Venereal Disease Control efforts in the extra military and industrial defense areas have been intensified. Diagnostic and treatment facilities in some non-defense areas and rural areas have been discontinued through the loss of both part-time and full-time personnel. During the past six months, venereal disease control efforts have been extended to heavy industry in the form of venereal disease education, surveys including serologic tests for syphilis and convincing plant officials that preemployment examinations are a great aid in venereal disease control. The venereal disease educational program is being developed and expanded, including schools, military establishments, civilian communities and heavy industry.

During the year, 83 diagnostic and treatment clinics were maintained and supervised under the direction of the Arkansas State Board of Health; 43 part-time clinicians directed the clinics; 3 full-time lend lease physicians directed venereal disease control in vital war areas; one full-time civilian physician was employed in a war area; 8 full-time epidemiological investigators were employed in case-finding.

During 1943, the following diseases and number of cases were treated:

Primary and Secondary Syphilis	1,391
Early Latent Syphilis	5,323
Late Latent Syphilis	5,121
Congenital	306
Not Stated	904
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SYPHILIS TOTAL	13,045
Chancroid	105
Lymphogranuloma venereum	24
Granuloma Inguinale	73
Gonorrhea	3,305

Tuberculosis Control

The activities of the Division of Tuberculosis Control have been largely devoted to a campaign for the early diagnosis of cases of tuberculosis. For the first time in the history of the state, the X-raying of all the college students was attempted. A number of the colleges have instituted this as a compulsory feature of their student health program and it is to be hoped the remainder of the colleges will fall in line. Again, for the first time, approval was given by the Arkansas Medical Society for conducting mass surveys among industrial workers. Due to the shortage of X-ray equipment this phase of the program has so far received scant attention. An order has been placed, however, for another X-ray machine, on which delivery is expected the latter part of June, 1944. With this new equipment it is hoped that this program may be pursued more vigorously.

Each county is advised of the names and addresses of persons rejected by the Selective Service, due to chest conditions, and it is the duty of the county public officials to urge this person to see his family physician; have a proper evaluation of his case made, and pursue the directions of that physician in recovering his health.

A full description of the department is to be presented at this annual meeting of the Arkansas Medical Society.

Maternal and Child Health

Regular maternal and child health activities decreased during the year due to the loss of personnel to the armed forces. A great deal of the time of the department was taken up with the administration of the Emergency Maternity and Infant Care Program in the state, funds for which became available May 19. In making funds available for this program, Congress set certain specifications and designated the administration of the program to the Children's Bureau, Department of Labor. This agency set certain other specifications, local administration of the program being designated to the various state health departments. The program met with difficulties and on October 15 the State Board of Health voted to discontinue this program when funds already in the state became exhausted. The program was revised, effective as of November 1, since which time a better understanding has existed and fewer difficulties have occurred. 3,047 applications for maternity care were approved during the year, 2,342 of these for hospital delivery. Care was given 117 infants under one year of age. 64 hospitals were participating in the program as of December 31.

Hygienic Laboratory

In the Hygienic Laboratory during the past fiscal year the decrease in specimens submitted by depleted county health units and private physicians has been more than offset by increasing needs of war areas and Selective Service Boards. The total number of specimens examined was 315,602 as compared with 223,217 for the previous year.

Blood specimens from 142,681 selectees were tested for

syphilis. In addition to this, the Serology Division has tested bloods from the Pine Bluff Arsenal, Maumelle Ordnance Plant, and various other of the war industries. Of a total of 279,916 blood specimens tested for syphilis, 16% were positive.

The total yearly number of examinations for gonorrhea has increased from 4,470 to 8,535. Of these, 16% gave positive results.

Examinations of animal brains for rabies totaled 387 with 54% positive; diphtheria, 804 with 7% positive; sputum for tubercle bacilli, 134 with 16% positive; tularemia, 1,457 with 9% positive; cultures for typhoid bacilli, 2,908 with 5% positive results.

In addition to these and other examinations the laboratory prepared and distributed typhoid vaccine sufficient to immunize 350,000 patients.

Malarial Control

During 1943, the department has operated malaria control programs in areas in Arkansas. The program is limited to areas having military reservations or war industries and comprises control measures of drainage, larvicide and education. The program has materially reduced the mosquito population density within the control zone and has aided in reducing the danger of malaria transmission.

A start has been made on a thorough study of the malaria problem in Arkansas by conducting engineering, entomological, and epidemiological surveys in ten counties. The results of these surveys will indicate the most practical measures that should be inaugurated to reduce the incidence of malaria.

MEDICAL EDUCATION AND HOSPITALS

A. J. DUNKLIN, Chairman

Your Committee wishes to submit the following reports on medical education and hospitals in the state.

As of June, 1943, of those students in the medical school 171 were enrolled in the army and 66 in the navy. Due to the urgency of war, our University has accelerated its curriculum admitting a new class approximately each nine months starting July 1, 1943, with 60 semester hours of premedical education required for entrance into the freshman class.

There were 283 enrolled in 1942-43. The four classes 1942-43 as follows:

Freshmen	82
Sophomore	71
Junior	60
Senior	70

70 were graduated.

The 1943 enrollment was as follows:

Freshmen	82
Sophomores	75
Juniors	67
Seniors	60

Of the total enrollment, 253 were from Arkansas, and 31 were non-residents. Fees for resident students for the four years are \$280 per year. Non-residents are charged \$505 per year.

By accelerating the medical curriculum, our schools are producing more physicians than ever before in the history of this country.

The faculty of the University consists of 30 professors and 112 instructors and lecturers.

The following data on hospitals is submitted:

Number of Hospitals	70
Number of Beds	15,977

Number of Bassinets	531
Number of Patients admitted	146,028
Average Census	12,301

Governmental Hospitals

Number of Federal Hospitals	12
Number of State Hospitals	4
Number of County Hospitals	1
Number of City Hospitals	4
Total	21

Beds	13,298
Bassinets	114
Patients Admitted	75,523
Average Census	10,653

Non-Profit Hospitals

Hospitals— Church	10
Non-Profit Association	13

Total	23
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Having the following

Beds	1,958
Bassinets	280
Patients Admitted	52,180
Average Census	1,298

Proprietary

Number	26
Beds	721
Bassinets	137
Patients Admitted	18,325
Average Census	350

These hospitals rendered the following types of service:

General Hospitals	60
Beds	8,323
Bassinets	509
Patients Admitted	133,521
Average Census	4,790
Nervous and Mental Hospitals	2
Beds	5,827
Bassinets	5
Patients Admitted	2,389
Average Census	5,928
Tuberculosis Hospitals	2
Beds	1,351
Bassinets	0
Patients Admitted	1,882
Average Census	1,336
Maternity Hospitals	1
Beds	30
Bassinets	13
Patients Admitted	37
Average Census	5
Industrial Hospitals	2
Beds	275
Bassinets	0
Patients Admitted	4,998
Average Census	119
Eye, Ear, Nose, and Throat Hospitals	1
Beds	8
Patients Admitted	120
Average Census	2
Children's Hospitals	1
Beds	83
Patients Admitted	609
Average Census	62
Isolation Hospitals	1
Beds	80
Bassinets	4
Patients Admitted	2,472
Average Census	59

It is our opinion that the medical school and our hospitals are serving their purposes admirably under the exigencies of the times considering the impairment of personnel.

From the above data on hospitals we wish to call to your attention the fact that government has approximately 33% of the hospitals in the state and treated more than 50% of total hospital admissions.

COMMITTEE ON MEDICAL ECONOMICS

H. E. MOBLEY, Chairman

(Read by the Secretary)

Medical Economics covers a number of fields that are important to the medical profession. Your committee, however, thinks that the most vital at this time is regimentation. Our efforts have been concerned with the study of this subject.

Regimentation of medicine, as set forth in the Wagner Bill and other bills that have appeared in the Congress of the United States, would destroy the independence of the medical profession as a whole and of each individual member. It would also encroach upon the personal rights of the citizens in selecting and securing the services of the physician of their desire.

The socialistic trend of certain governmental officials and the influence of certain groups within our own ranks in magnifying the problem of supplying service to the indigent has had a tendency to confuse the issue.

The subject should be broken down and separated; first independent medicine and second, supplying medical service to the indigent. The American system of independent medical service has developed the most effective and widely distributed medical care to the greatest number of people of any known system. We have with us a definite problem of furnishing adequate medical service to the indigent. This problem should be given definite consideration.

In view of the facts set forth we would like to submit the following recommendations for the action of the Arkansas Medical Society.

1. From the standpoint of legislation, independent medicine be definitely divorced from the subject of supplying medical service to the indigent. That the Arkansas Medical Society go on record as opposed to any plan or legislation that in any way encroaches upon or involves the independence of the medical profession.

2. That we encourage acceptable insurance plans and legislation to supply adequate medical service to the indigent. We would like to suggest that any plan of this nature be carried out with the proper principles as applied to free enterprise in business.

3. Your committee recommends that every member of the medical society talk with and keep in touch with his congressman and senator. Explain to them our position in the matter and find out how they feel.

4. We note that there is a tendency on the part of the recent graduate to be willing to accept a position or job and take the line of least resistance. He seems to be indifferent toward the subject of independent medicine. We would like to suggest that the Arkansas Medical Society recommend to the Dean of our Medical School that our students be given information which will acquaint them with the privileges of independent medicine. We would also like to recommend that each individual member of the medical profession take time to counsel

with the students of medicine and build up an education policy within the profession.

5. We would also like to recommend that each member in his daily practice take a little time to explain to the public the importance of maintaining our present system of independent medicine. We know that the public does not want regimented medicine, but under the guise of social security as set forth in the Wagner Bill, they might accept it if not warned.

COMMITTEE ON SCIENTIFIC EXHIBIT

M. J. KILBURY, Chairman

Due to the amount of work entailed in setting up an exhibit at the present time and because of the small attention which such an exhibit receives, the Committee recommends that the Society have collapsible booths made which may be used for scientific exhibits. These could be readily transported to the place of meeting each year and would make participation in the exhibit much easier for exhibitors as well as make the exhibit much more attractive.

Due to the fine efforts of Paul L. Day of the University of Arkansas School of Medicine, a splendid exhibit has been arranged for this meeting. The Committee urges you to give these exhibits special attention. And it would not do any harm to give a word of encouragement to the exhibitors.

REPORT OF COMMITTEE ON CANCER CONTROL

FRED HAMES, Chairman

During the past year your Committee on Cancer Control has been limited in its activities due to the war. However, we feel that much has been accomplished, and we hereby submit a report of our activities during the past year and our recommendations to the Society.

In 1943, the first school for the workers of the Women's Field Army was held in Jonesboro. This year they requested that a second school be held and this was arranged by Mrs. W. R. Brooksher, the State Commander of the Women's Field Army. The attendance was excellent and great progress is being made in the community.

At the request of the Medical Society of Union County, a cancer clinic was held in El Dorado in which all of the doctors of the Society participated and arrangements were made for the formation of a chapter of the Women's Field Army to follow up the work accomplished. It is hoped that later a school can be held for the workers of this community. Free diagnostic clinics were held in Nevada, Polk, Sevier, Craighead and Sebastian counties.

Your committee commends the faithful and untiring services of Mrs. W. R. Brooksher in her capacity as head of the Women's Field Army for this state. Her work in this capacity has become so heavy that this committee has approved the employment of a full-time stenographer.

Through the efforts of Mrs. Brooksher and the kindness of Mr. Gene Baim, attorney of Pine Bluff, the Arkansas Division of the Women's Field Army was incorporated at practically no expense. This had been requested by National headquarters.

This committee notes an increasing interest on the part of the public in the field of cancer control and recommends that it be authorized to establish the policies of this Society, and to cooperate with voluntary and other

agencies in all problems pertaining to cancer in the State of Arkansas.

COMMITTEE ON THE HEART

J. N. COMPTON, Chairman

Report of Re-Examination of 1,000 Men Rejected by the Induction Station of the Armed Forces Because of Cardiovascular Disease

The following is a portion of the report submitted to the National Headquarters Selective Service:

For the purpose of re-examining registrants who had been rejected by the Induction Station of the Armed Forces because of organic heart disease, hypertension and tachycardia, a Special Cardiovascular Medical Advisory Board was set up in Little Rock, Arkansas, composed of Dr. O. C. Melson, Professor of Medicine, University of Arkansas Medical School, Dr. S. C. Fulmer, Assistant Dean and Professor of Medicine, Dr. J. N. Compton, Associate Professor of Medicine, Dr. D. T. Hyatt, Associate Professor of Medicine, Dr. F. W. Harris, Assistant Professor of Medicine, and Dr. S. T. W. Cull, Assistant Professor of Medicine.

Supplementing the Special Cardiovascular Medical Advisory Board established in Little Rock, three members of the medical advisory board in Fort Smith functioned as a special cardiovascular group, and one member of the medical advisory board in Fayetteville functioned separately as such an examiner. The three men constituting the cardiovascular group in Fort Smith consisted of Dr. A. A. Blair, Dr. C. T. Chamberlain, and Dr. Martin M. Even, and in Fayetteville, Dr. Allan A. Gilbert examined men adjacent to that locality.

Prior to submitting any registrant for re-examination by the Special Cardiovascular Medical Advisory Board the Form DSS 221 showing the Induction Station physical examination was carefully reviewed by the State Medical Officer, and all cases with multiple causes for rejection or questionable defects other than cardiovascular were eliminated from this re-examination.

The Special Cardiovascular Medical Advisory Board has examined approximately fifty men per week during a period of twenty weeks. The re-examination has been made in accordance with MR 1-9. The rejected registrants were largely from the Armed Forces' Induction Station, Little Rock, Arkansas, with a minor portion rejected at Shreveport, Louisiana. The result of this examination is as follows:

Number of registrants re-examined—1,000.

Number of registrants re-examined in which the medical advisory board failed to concur in the findings of the induction station—254 or 25.4%.

Number of cases re-examined who had been rejected because of organic valvular heart disease—687.

Number of rejectees (valvular lesions) in which the medical advisory board failed to concur in the diagnosis—219 or 32%.

Number of cases re-examined who had been rejected because of hypertension—191.

Number of rejectees (hypertension) in which the medical advisory board failed to concur in the diagnosis—18 or 9%.

Number of cases re-examined who were rejected because of tachycardia—123.

Number of rejectees (tachycardia) in which the medical advisory board failed to concur in the diagnosis—18 or 14.6%.

It will be seen that predominance of the non-concurrence of findings occurred in the organic valvular lesion group.

COMMITTEE ON MATERNAL AND CHILD WELFARE

S. A. THOMPSON, Chairman

This Committee had several meetings with the Council and State Health Department the past year. The last one included Dr. Daily of Children's Bureau, Washington, at which time some of the misunderstandings and uncertainties were cleared up.

As you know the Council refused to rescind its disapproval of this program but left it so that members of our society could participate if they desired.

This Committee was asked to continue conferences with State Health Department as an aid to it and our members. Indications are that a majority of our participating members are satisfied, not with government controlled practice, but with the manner in which it is now conducted.

A meeting with the State Health Director, Dr. Ross, was held yesterday when further suggestions were presented. Details are too long to give here but will be presented to the Council and if approved, published in an early issue of The Journal.

It is a pleasure to report that one of the main objectives of State Health Director, Dr. Ross, is that of complete cooperation with our Society. As usual our state secretary has rendered valuable assistance to this committee.

ADVISORY COMMITTEE TO THE AUXILIARY

L. J. KOSMINSKY, Chairman

The Auxiliary to the Arkansas Medical Society has done very good work in Education and Public Health, Student Loan, Physical Examination, Doctor's Day Observance, Essay Contest, Doctor's Aide Corps, Cancer Control and Hygeia.

The President of the Auxiliary wrote a letter to the Senator of Texas and to the Congressman of 4th Arkansas District and 1st District of Texas relative to defeating the Wagner-Murray Bill. She received encouraging replies from each one. Their activities, like ours, have been somewhat limited so far as visiting over the state is concerned, owing to war conditions restricting traveling facilities.

We wish to compliment them on the excellent work they have been doing in the past several years and thank them for the hearty cooperation given the Arkansas Medical Society.

COMMITTEE ON SYPHILIS CONTROL

LOUIE G. MARTIN, Chairman
(Read by the Secretary)

It is with pleasure that we submit the following report. Due to transportation, etc., it has been impossible to hold a full meeting of your Committee. This Committee, however, wishes to endorse the work done on the control of syphilis by our State Board of Health.

The following is a summary of the work done by the State Board of Health.

A special effort has been made for the control of

syphilis near all military and defense areas.

Diagnostic and treatment facilities were greatly expanded.

Act No. 240, to prohibit prostitution, lewdness and assignation, was passed and adopted by the state legislative bodies.

Adequate local venereal disease control ordinances were adopted by several city councils.

Throughout the state 84 diagnostic and treatment clinics were maintained and supervised by the State Board of Health. Forty-six part-time, and one full-time clinician was employed. Three full-time United States Public Health lend-lease venereal disease control officers directed venereal disease control activities, under the supervision of the State Board of Health, in the large extra military areas.

The following venereal diseases were treated during 1943:

Primary and Secondary Syphilis	1,391
Early Latent Syphilis	5,323
Late Latent Syphilis	5,121
Congenital Syphilis	306
Not Classified	904

Total Syphilis Treated	13,045
Chancroid	105
Lymphogranuloma Venereum	24
Granuloma Inguinale	73
Gonorrhea	3,305
Number of blood Wassermanns,	
State Laboratory	130,926
Spinal fluid examinations	1,405

Your committee has no special recommendations to make at the present time.

LIAISON WITH ARKANSAS TUBERCULOSIS ASSOCIATION

A. C. SHIPP, Chairman

Your Committee on Liaison with the Arkansas Tuberculosis Association reports as follows. During the past year there has been harmonious co-operation among all the agencies of the state, viz., the Arkansas Medical Society, the Arkansas Tuberculosis Association, the Division of Tuberculosis control of The Arkansas Board of Health and the two sanatoria.

The Arkansas Tuberculosis Association in annual session last week extended greetings to the Arkansas Medical Society and a vote of thanks for its hearty cooperation in the program for tuberculosis control. A resolution was also adopted to introduce in the coming legislature a bill providing for the X-ray examination of all teachers and school personnel as a part of the physical examination in order to eliminate open cases of tuberculosis from our public schools. The Tuberculosis Association respectfully requests the Arkansas Medical Society to again endorse this legislation and to instruct its Committee on Legislation to lend its influence and support to the bill when introduced. The bill introduced last session of the legislature died on the calendar because of late introduction. The only question raised was by the Department of Education on the ground that it might work a hardship on some teachers. This objection no longer is valid as funds can be provided, where necessary, by local tuberculosis associations.

The objectives of the Arkansas Tuberculosis Association for 1944-45:

1. To strengthen and encourage county organizations to cooperate and carry on their own programs.

2. An educational campaign to demonstrate to labor and management the importance to both groups of X-ray surveys for tuberculosis case finding in industry.

3. To aid in the creation of an environment free from tuberculosis in the schools of our state by helping to provide X-ray examinations for those individuals who are in continuous contact with school children, such as teachers, bus drivers, janitors and food handlers.

4. To help create a more effective program of tuberculosis control among our Negro population.

5. To lend every assistance to the State Hospital for Nervous Diseases to provide adequate facilities for the segregation of its tuberculous patients.

6. To cooperate in every way with the physicians and the public health official agencies in their programs for tuberculosis control.

Your committee recommends that the Arkansas Medical Society endorse the program of the Arkansas Tuberculosis Association as set out in this report and that the Arkansas Medical Society endorse the proposed legislation and so instructs its Committee on Legislation.

COMMITTEE ON INDUSTRIAL HEALTH

E. E. BARLOW, Chairman

During the past year, your Committee on Industrial Health has continued the study of the needs of the physicians in the state for more information concerning the care of the industrial worker. We stated in our last report that the interest of this society should not be limited to occupational diseases alone but should extend to all causes of lost time disability by workers in industry.

Acting upon this premises your Committee chairman discussed with Dr. A. C. Curtis, Director, Division of Tuberculosis Control of the Arkansas State Board of Health, the proposition of his department making a survey and examining the industrial worker in the various plants of the state for tuberculosis. Dr. Curtis agreed to carry out this program provided it met with the approval of the entire committee.

In June, of last year, following the meeting of the House of Delegates of the American Medical Association, your committee chairman discussed this proposition with Dr. Carl M. Peterson, Secretary of the Council of Industrial Health of the American Medical Association. The object of the conference was to secure permission from Dr. Peterson before presenting the proposition to the committee as a whole.

Dr. Peterson stated that his department regarded tuberculosis case finding in industry as providing a most useful function provided certain safeguards are kept in mind. These are (1) that the personnel undertaking technical procedure and diagnostic interpretation is professionally competent, (2) that individuals with positive findings are referred to private physicians or other properly authorized community health agency for recheck and individualized case management.

In any public health activity of this kind, of course, it is desirable on every count that the medical profession be fully advised of what is contemplated so that there can be proper interpretation between the surveying agency, individual physicians, and medical organizations.

On October 23, 1943, your chairman called a meeting of the Committee on Industrial Health and presented the above facts. After some discussion, approval was given the Arkansas State Health Department through its Divi-

sion of Tuberculosis Control for the holding of diagnostic mass X-ray surveys in industry. On March 23, 1944, Dr. Curtis gave a report on his work during the year which is embodied in this report as follows:

2,071 individuals have been X-rayed in industrial plants in the state by means of a portable 35 mm. photofluorographic unit. Interpretation of this number of miniature films gave the following results:

3 cases of active reinfection tuberculosis, requiring immediate therapy.

13 cases of arrested tuberculosis, requiring periodic examinations.

22 cases diagnosed as having pulmonary conditions other than tuberculosis.

62 cases which were suspicious and requiring careful physical examinations and immediate rechecks with large X-rays.

Of these sixty-two, thirty-six were re-X-rayed on 14x17 films by private practitioners. On the basis of physical examinations and the large X-rays these thirty-six were diagnosed as:

6 active cases of reinfection tuberculosis requiring immediate therapy.

11 cases of arrested reinfection tuberculosis requiring no therapy but necessitating periodic check-ups.

5 were still considered to be suspects requiring further study.

14 were judged to be free from evidence of clinically active reinfection tuberculosis.

10 were diagnosed as having pulmonary conditions other than tuberculosis.

Thus, out of a group of 2,071 unselected individuals, thirty-three previously unsuspected cases of adult reinfection pulmonary tuberculosis were discovered. This program will be expanded as soon as additional X-ray equipment can be obtained.

The foregoing is a numerical accounting of the activities of the Division of Tuberculosis Control relating to industries. I would like to point out to you that as a result of the survey of only 2,071 individuals, a total of eighty-five individuals were referred to their private physicians for additional study and that of this number of cases, this department knows of thirty-six X-rays having been made by private practitioners.

As a result of this report, it would thus seem to your Committee that such activities, rather than encroaching upon the private practitioner's field, are materially bringing new patients to him. This is, of course, not such a factor at the present time but should serve to demonstrate that this program will always be of a distinct value to the private practitioner.

It is noted that this program is limited to industries and that the service is to be rendered free of charge to all parties concerned.

The personnel of any one industry will be examined by the state-owned unit and the resulting films interpreted by the Director of the Division of Tuberculosis Control. The employee is to be informed that he falls into one of three classes; (1) apparently normal, (2) suspicious, or (3) definite chest pathology. The diagnosis will be furnished direct to the family physician of the employee.

Your Committee feels that Dr. Curtis has done a splendid job considering the equipment at his disposal. The committee also feels that the organized medical profession in Arkansas should maintain a constant interest in these industrial health problems or relinquish this leadership to other extra-professional agencies.

Last, but not least, your Committee recommends that

this work be carried on by the Division of Tuberculosis Control of the State Board of Health. In our report of 1942, your Committee set up a definite program which was adopted by the reference committee. The State Board of Health at that time agreed to make an effort to carry out the greater part of this program. The work done by Dr. A. C. Curtis this past year is only the beginning. Our hope is that as time goes on our State Board of Health will be able to take on work in other fields of industrial health.

COMMITTEE ON MENTAL HYGIENE

N. T. HOLLIS, *Chairman*

When our last report was made one year ago, the new State Hospital admission law had just gone into effect. Many sincere persons believed that this act would result in a marked increase in the patient population of the institution. The act was approved on March 18, 1943, and has been in operation a little more than a year. The patient population of the State Hospital on July 4, 1942, was 4,713. This is the high point in the number of patients since it was built in 1882. The number of patients in the institution at the time of writing this report is 4,662. This is an actual decrease in population during the past 19 months of 51 patients. Over the past several years there has been an annual increase of 150 patients. If this same ratio of increase had occurred over the past 19 months, the population would have been approximately 4,950 instead of 4,662 as at present. This law simply places in the hands of the hospital administrators the responsibility of deciding the eligibility of patients who desire admission. It has attracted the attention of many other states.

A new building has just been completed on the grounds of the Little Rock unit of the State Hospital. It will house approximately 400 patients. It will be occupied in the next few days. The War Production Board has granted approval for priorities for the construction of a \$200,000 building at the Benton unit. This will house approximately 400 patients. Construction of this unit will be started in the very near future or just as soon as plans are completed. An application for the construction of added facilities to the extent of \$50,000 for the care of colored female patients at the Little Rock unit is now before the War Production Board in Washington. We have every reason to believe that this will be granted. This will relieve the overcrowded conditions of the institution. All this will result in much better care of the mentally ill of the state.

We would again like to call your attention to the need for an active statewide mental hygiene program. To this date, we have not spent one cent on a program for prevention of mental diseases. We must consider every problem child in this state as a potential candidate for the reform schools, the State Hospital, or the penitentiary. The public must be educated to the necessity for such a program.

We would also like to call your attention to the need for a thorough psychiatric examination of every inmate of our penal and correctional institutions. It is not necessary to go into a detailed discussion of this question. The need is quite obvious.

We want to emphasize the importance to the School of Medicine of the University of Arkansas of a psychiatric institute in connection with the Medical School for a more

thorough and intensive training of the students in psychiatry and mental hygiene. 55-60% of all hospital beds throughout this country are occupied by mental and nervous patients. This is the magnitude of this problem. It is reasonable to assume that the same ratio of patients who go to any doctor's office will have some psychiatric aspect to his complaints, and the medical profession should be more highly trained in this branch of medicine in order to be better able to diagnose and treat these cases.

COMMITTEE ON MEDICAL SERVICE AND PUBLIC RELATIONS

P. W. LUTTERLOH, *Chairman*

(Read by the Secretary)

The record established by the medical fraternity in the United States during recent years is a brilliant one. The ordinary span of life has been materially lengthened, the death rate, especially among children, has been lowered, and the treatment of disease has been stripped of much of the pain and after effects to which we were formerly accustomed. Many diseases once considered beyond the pale of doctors have been brought under control. Aided by the chemist, whose researches are constantly revealing remedies with wonderful healing powers, the physician of today seems at times almost a miracle worker. Who can measure the beneficent results of the sulfa drugs? On the battlefields of Europe we lose less than two percent of the wounded.

But there is another side of the picture which is not so bright. The record of rejection by the military agencies reveals a deplorable situation. Scores, if not hundreds, of thousands of our young men are declared unfit for military duty because of physical defects or ailments. In the schools we find literally millions of children with defective eyesight and hearing, not to mention bad teeth, infected tonsils, adenoids, sinus, etc. Clearly the medical fraternity has not discharged its full duty.

Nor can the profession offer as an alibi that its hands have been tied. By legislative enactment and judicial decision, it has been given carte blanche for everything it wishes to do. It is allowed unrestricted control over the training and licensing of doctors, the training of nurses, the regulations of hospitals, and the liberty to regulate fees even to the extent of maintaining a gentleman's agreement. Most of the members of this committee saw the law enacted providing the "basic science" examination. The doctors who lobbied for the bill frankly admitted that its purpose was to eliminate "off brands" of practitioners. When the teaching profession undertakes to raise the requirement of teachers there is always opposition from the legislators who insist on protecting their old teacher friends back home who cannot meet those requirements. Just now Arkansas has 4,000 "emergency" teachers in service to take the place of properly trained teachers out for the duration. The medical profession makes no allowance for the absence of some 55,000 doctors now in military service or for other shortage. In view of this fact alone, the profession should remember the French saying, "noblesse oblige."

It has been well said that only the wealthy and the indigent poor have access to the best of medical service. The wealthy can pay for it, and genuine charity cases are often treated gratis.

From the results of the surveys cited in literature, I note that the majority of people represented in the survey

offer no serious objection to the fees paid for medical care. The findings are probably correct. For, while the payment of a modest ten or fifteen dollar doctor's bill usually brings about an upset in the family budget, causing deprivations to the family, few persons could be found who object to deprivations if thereby they can save the life or even contribute to the well being of their loved ones. In the case of prolonged illness and the consequent heavier bills, arrangements can usually be made for installment payment which can be managed without too serious dislocation of the family budget. From the people included in this category, there is little danger that the demand for radical proposal of social medicine such as the Wagner Bill, will find general support.

But, there is a field where the soil is ready to receive such ideas. Let me give some attention to that field.

I refer to the rural areas and the underprivileged groups in our cities and larger towns. In general, I am referring to low income groups and to areas roughly described as lying five to fifteen or twenty miles from the residence of the nearest doctor.

Let me remark first on the rather obvious fact that practically all good doctors have moved to the urban centers. The old country doctor who answered calls day or night, without a question in advance as to whether he would be paid, who carried his medicine with him, that doctor has "gone with the wind." As a rule, the only doctors to be found in the areas mentioned above are those who have not been able to establish, as yet, city practice, or who have given up hope of ever doing so. In many instances, they can and do good service, but their best is seldom good enough.

Well established city or large town doctors are seldom willing to practice in the country. If they consent to make a visit into the country, they charge not only their regular fee but in addition, a mileage fee fixed by law. Incidentally, the rate has not been lowered since the days when there were few if any good roads, and when the horse was the sole motive power. In the days when the rate was fixed, a trip of fifteen to twenty miles meant a full day of hard riding or driving, often in inclement weather. Now the trip can usually be made in an hour at the most and in utter comfort insofar as the weather is concerned. By the time the mileage is added to the fee, the patient finds himself facing a bill of fifteen to twenty-five dollars. To a man with a big family and with an average annual income of \$400 to \$600, such a bill is manifestly unreasonable. But that is not all. Generally speaking, the city doctor will answer calls only when certain of payment. Since few farmers or non-union workers seldom have any cash on hand or any well defined pay check income, the patient is obliged to secure a guarantor of the forthcoming bill.

A story, an experience of a friend of mine. One night he got up early to catch a train. The train was late, so he stepped into the lobby of a hotel. There the city marshall was calling up doctors, one after another, in an effort to get help for a woman in labor twenty miles away. No one in town knew the man for whom he wanted a doctor, so no one would vouch for his paying ability, obviously poor, to judge from his car and clothes. Not a doctor would go. At daylight, the man climbed into his car and started home. How the woman fared, he does not know.

There is another angle of the situation. I find that few established doctors will attend a woman in labor except in a hospital. The hospital bill, plus an ambulance bill, plus a nurse, plus the fee or fees, makes a baby a most

expensive luxury. In fact, there are scores of thousands of married couples who sidestep having children on this account alone. How can an ordinary day laborer or share-cropper have children at such a cost?

I have not discussed the matter of surgery and the expense incident thereto. That opens up a new field. Generally speaking, people can pay ordinary fees for medical service, but the surgical work is something else. Let me give you an example, as related to me by a friend. Last year a young lady, residing in Tennessee, had been bitten by a spider, so she thought. Her physician urged her to go to Memphis for an examination. The specialist advised an operation. He told the man confidentially he did not know what her trouble was but that she needed the operation anyway. He consented. Among other things, he tested the fluid in the spinal column. He states he has never reported on his findings. Result: Loss of a month's time from her work, a doctor-hospital bill of \$500, and no appreciable results.

I think we may say with some reason that the demand for socialized medicine comes from the complaint about exorbitant bills for surgical work, mending broken bones, obstetrical fees, forced entry into hospitals, etc., than from all other sources combined.

Suggested remedies. Lowered mileage rates to out of town patients. Less exacting rules for payment. Less demand for hospitalization. Less expensive hospital rates. More liberality as to the training of nurses for country work. Trained midwives.

The high powered surgeons have a sliding scale of charges. The difficulty of the risk of the operation seems to be without consideration. The only question is, how much can the patient pay? To determine the answer to this question they ask the doctor who sent or brought the patient, the banker who handles his account and any others who can furnish information. That racket is a decidedly sharp thorn in the flesh of the public. The surgeon defends his high charges on the ground that he does a great deal of work gratis. But the fact remains that he usually grows rich in spite of his charity work.

Perhaps the idea should be: How little can I afford to charge this patient and still receive a reasonable fee for my work? But let us consider a modified application of the principle of charging all the "traffic will bear." Suppose the surgeon has two patients in the hospital at the same time. One is a farm or plantation owner, the other his "hired man," or tenant. Both need the same operation. The farmer can stand a reasonable fee and will not object to paying it. The other cannot stand any considerable fee and yet is wholly unwilling to accept service as a charity. What should the surgeon do? Would it not be a just and satisfactory solution to make the fees somewhat proportional to their relative ability to pay? In other words, is there any valid reason why you should not adjust your fee downward instead of upward?

Now that I have sketched some of the conditions that create a demand for socialized medicine, let me discuss some of the remedies suggested. Personally, I do not think you need have any apprehensions about the passage of the Wagner Bill. It is wholly totalitarian in its nature. It denies the doctor the right to choose his place of practice and the right of the people to choose their doctor or their hospital and it involves a staggering expense. But the defeat of the Wagner Bill does not mean there will be no further attempt to cut down the cost and the availability of medical service in the country. The people of the world are becoming conditioned in their thinking toward social reform. We shall have in England

and in America a more or less socialized state after the war. We may as well get ready for it. Socialized medicine in some form is bound to come. We can only modify, we cannot hope to defeat, the movement.

a. Free clinics. They can help materially, though in only a very limited way.

b. Co-operative groups can function well in certain compact areas where the people have a fairly stable income, that is, factory workers. I note that certain large plants furnish medical attention free to all employees and their families. Others assume a definite part of the expense. This latter seems decidedly the better practice. We do not wish to pauperize our people: free medical care is as bad as free education or free religion.

c. Insurance. That plan is workable where people have a steady income, though small. We see how that law works in certain types of insurance promoted by the Metropolitan and other companies. But unless the family has some dependable income, it cannot meet the fifteen or twenty-five cents a week premium.

A final word. As I indicated above the medical fraternity has enjoyed, hitherto, the unbounded support of the American people. It has things its own way. The people justly regard it as the guardian of public health. And it has, in the main, been true to that trust. But times are bringing change. The fraternity must not exploit the people for its own purposes. It must not become self-seeking beyond a reasonable remuneration for its services. It must avoid the very appearance of autocracy. It must keep in mind always that the people and not the fraternity are the ones whose interests come first. "Service above self." If they will keep that in mind, the spectre of totalitarian social medicine need not give needless concern.

THE STATE MEDICAL BOARD OF THE ARKANSAS MEDICAL SOCIETY

D. L. OWENS, Secretary

In June, 1943, Drs. L. J. Kosminsky, Robert Hood and Robert J. Haley were re-appointed to this Board for a period of four years.

The Board has had three call meetings and two regular meetings. One of the call meetings being necessary due to the acceleration of the medical course, as given under the Army program and the graduation of physicians three months before the regular June graduation. This meeting was held in order to give these graduates the examination for state license before they left for their respective internships. This accelerated course given in the schools will necessitate three or four examinations each year instead of the two examinations as have been previously held.

During the past year the licenses of two physicians have been restored.

During the past year one hundred eight students from the University of Arkansas Medical School took their primary examinations covering the freshman and sophomore work as given by the University School of Medicine. One hundred ten students from the University of Arkansas Medical School took their final examinations covering junior and senior years' subjects. Seven graduates of the University of Arkansas Medical School took their complete examinations March 23rd and 24th, 1944.

During the past year three applicants from out of state medical schools have taken the Arkansas Board. They were:

One from Tulane School of Medicine,

One from University of Tennessee Medical School, and

one from Johns Hopkin's School of Medicine.

During the past year this Board has granted seventeen licenses by reciprocity and during the past year this Board has certified sixty-three licentiates to other states.

The President and Secretary of this Board attended the Federation Meeting of the State Boards in Chicago this year. This meeting was held in conjunction with the meeting of the Council on Medical Education.

For some time it has been advocated that the American Medical Association open a Bureau of Information and maintain such a Bureau in Washington, D. C., in order that our representatives might be able to secure such information as they might desire regarding the practice of medicine. Also, that we might have a representative in Washington to study all bills, which might affect the practice of medicine, and keep us informed on such, but this has not been done. At this meeting in Chicago, it was announced by a group of western states, that they had united into a body for such a purpose and that they will establish and maintain such a bureau soon. Although they will first give the American Medical Association this opportunity as it is the logical body to do so. But if the American Medical Association does not establish such a bureau, then these states will establish this Regional Bureau for their benefit. California, Utah, and Colorado are a part of this group. I think such a movement should be discussed by this body and that our delegates to the American Medical Association be instructed to vote for such a movement.

This Board has had a great deal of difficulty during the past year in keeping in communication with many of the physicians, due to the war. Some physicians will probably not be listed under the proper heading in the directory due to this difficulty and also due to not answering communications sent to them. Our Board at all times will be glad to confer with any physician regarding the medical practice act and the enforcement of same.

REPORT OF THE DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

E. E. BARLOW

Dr. Barlow called attention to the proceedings of the 1943 annual session of the American Medical Association as published in the August, 1943, issue of The Journal of the Arkansas Medical Society. He emphasized the accomplishment of that meeting as the formation of the Council of Medical Service and Public Relations and outlined the duties of this Council. It is felt that this body will obtain results for the medical profession.

REPORT OF THE COUNCIL

CLYDE McNEIL, Chairman

September 12, 1943—Authorized the Nevada County Medical Society to continue its agreement with the Post-War Planning Committee of the Farm Security Administration if the county society deemed this advisable. Authorized waiver of membership assessment for members in military service in those instances where the county society did not make payment. Voted to disapprove further participation in the Federal obstetric and pediatric care program for the wives and infants of enlisted men. Discussed S. 1161 and plans to combat this legislation. Urged councilors to arrange for sug-

gested appointments for expiring terms on the State Board of Health.

October 31, 1943—Met in joint session with the Arkansas State Board of Health, the Maternal and Child Welfare Committee and representatives of the Children's Bureau for a discussion of the Federal MCH plan. Adopted a resolution disapproving the plan in principle but permitting individual members of the Society to participate if they so desire. Expressed appreciation of the Society to Dr. W. B. Grayson, retiring state health officer, for his cooperation. Offered Dr. T. T. Ross, incoming health officer, full support of the Society.

REPORT OF TREASURER

PAUL L. MAHONEY

April 6, 1943—March 29, 1944

Balance April 6, 1943:

Pulaski Federal Savings & Loan Ass'n.	\$5,000.00
Commonwealth Federal Savings & Loan Ass'n	2,500.00
War Bonds	900.00
Checking Account	7,246.83
	<u>\$15,646.83</u>

Receipts:

Transferred from Secretary	13,000.00
War Bonds	2,000.00
Dividends, Savings & Loan Ass'ns	225.00
Interest, War Bonds	22.50
	<u>15,247.50</u>
	<u>\$30,894.33</u>

Disbursements:

Vouchers 1405 to 1483, inclusive	\$11,248.31
	<u>\$11,248.31</u>
	<u>\$19,646.02</u>

Balance March 29, 1944:

Pulaski Federal Savings & Loan Ass'n	\$5,000.00
Commonwealth Federal Savings & Loan Ass'n	2,500.00
War Bonds	2,900.00
Checking Account	9,246.02
	<u>\$19,646.02</u>

REPORT OF THE SECRETARY

W. R. BROOKSHER

The membership of the Society today is 1,001. One year ago it was 960. 241 of the members of the Society are in military service. The following county societies have paid the annual membership assessment of their members who are in service: Benton, Chicot, Clay, Crawford, Greene, Hempstead, Independence, Jefferson, Johnson, Lincoln, Lonoke, Miller, Mississippi, Ouachita, Pulaski, Sebastian, Washington and Woodruff. In the case of members from other county societies, the Council has waived the assessment and they are continued in good standing.

The secretary's office has been unusually busy during the past year as new duties arise and as new problems develop requiring the attention of the membership. Especial effort has been made to maintain contact with

members away in military service through The Journal and by monthly bulletins. These efforts have been favorably received and it is felt that these members in service appreciate even this limited contact with home. It seems desirable and proper that the Society give earnest attention to the day when these physicians will return to the state and re-engage in the practice of medicine. It should be the function of those at home to do all within their power to maintain our present satisfactory system of medical practice and to take steps which will facilitate the demobilization of our members in the armed forces and their return to private practice.

Your secretary has continued to act as Arkansas Chairman, Procurement and Assignment Service. This becomes no less pressing and demanding as the war continues. There is urgent need at this time for young physicians, physically qualified and who can be spared from civilian practice, to enter the armed forces. It is hoped that these needs of the armed forces will continue to be met.

Major attention has been focused this year on intervention and proposed intervention by the Federal government in the practice of medicine. The views of the Council and of the Committee on Maternal and Child Welfare with respect to the Federal program for care of the wives and infants of enlisted men has been given you by that committee.

There is an alarming complacency with respect to the Wagner Bill by physicians generally. Action on the part of all physicians is needed if public opinion is to be marshalled against this legislation which threatens the entire structure of medical care in the United States. With enlightened public opinion and concerted action, the Wagner Bill can be stopped. It is possible to show the public that this is not the answer to the problems which the bill attempts to solve. If the Bill does not pass now, rest assured that there will be another time, a time when unemployment, low wages and perhaps actual want follow a wartime boom, when the social planners will come forth with a newer and bigger plan for regimenting medical care. That is, unless the medical profession proves conclusively in the meantime that it has a substitute for government medicine. The prospect of "free" or "cheap" medical care is alluring to many of our citizens. Such a plan is a great talking point to the politician and the social worker, a probable vote-getter of much magnitude. Plainly there is a need for some plan which would spread the cost of illness, a plan which would protect the patient's self-respect by allowing him to pay his own way. Federal compulsory health insurance with its implications of political control and cheapened medical care is not the answer. Yet, before the agitation for socialized medicine again comes up, the medical profession must have proved its ability to provide a sound plan of this kind on a voluntary and local basis, or run great risk of having legislation foisted upon them which will permanently cripple their capacity to help the sick. This plan can be made popular and will be the answer. There is no one plan which will meet the need in all areas of these United States. It would seem that the most important possibilities at this time are physician-sponsored plans for medical care or the provision of commercially available insurance plans of an acceptable nature. The medical profession of Arkansas is challenged to meet this need now.

For the kindly assistance and full cooperation which we have received from the officers and members in the work of this office during the year, we express our full appreciation.

REPORT OF COUNSEL

HON. PETER A. DEISCH

In the interest of brevity my report may be considered as included in that of the legislative committee, with but two additional comments.

Labor in Hospitals

All except state-owned hospitals are subject to the provisions of the state labor laws concerning hours of employment for females. The labor law was amended by Act 70, 1943, and provides that no female may be employed for more than 8 hours in any one day, or more than 6 consecutive days in any one week, nor may she receive less compensation than \$1.25 a day if she has had 6 months practical experience in that industry, or \$1 a day for inexperienced workers, or less than 6 months practical experience, unless paid time and one-half for additional time, not to exceed one hour in any one day. But the Commissioner of Labor may grant a permit in his discretion for overtime of more than one hour a day, or for labor 7 days a week, provided the overtime rate shall apply on the 7th day, and provided the salary paid the female employee is not less than \$35 a week.

Wagner-Murray-Dingell Bill

The American people do not seem to favor S. B. 1161, now pending in the Congress. The following item from the April 1944 "Nation's Business" quotes the result of a survey by the Opinion Research corporation, as follows:

Your Post-War Labor Relations Program probably will include group medical insurance for workers and families—and an increased cost of doing business.

Nation-wide study by Opinion Research Corp. shows only 8% of the population favors federal health insurance and care supported by increased Social Security pay roll deductions.

But 39% favor systematic prepayment of medical care on insurance principles under employer sponsorship. For whole nation, 63% favor some plan "to make it easier to pay doctor and hospital bills."

Every year 58% of population see a doctor (not including dentist). But only 33% are home in bed more than 1 day.

Measured in family units, 59% spend less than \$50 yearly for doctors; 34% spend over \$50, and 7% don't know total.

On reasonableness of doctor bills 77% of total population said not too high; while 21% said "too much." (On hospital bills, 17% said too much.)

Today, 22% of U. S. workers are covered by employer-supported medical plans at group-insurance rates ranging from 80c to \$2 weekly pay roll deductions, varying with number of dependents; and 41% more say they would be interested in such a plan.

Significance: approximately 80% of U. S. population find prevailing medical system satisfactory and adequate; remaining 20% feel family medical costs are burdensome.

This is in accordance with the views expressed by the Council on Medical Service & Public Relations, as found in the March 1944 issue of our Journal. All of which indicates that organized medicine is not temperamentally capable of sitting down in sack cloth and ashes, endlessly intoning: "O tempora, O mores!"

The following proposed amendment to the by-laws of the society, introduced at the 1943 Annual Session and published twice in The Jour-

nal of the Arkansas Medical Society, was read by the secretary:

Chapter V. Section 1.

To amend the fifth sentence which now reads:

"The committee shall report the result of its deliberations to the House of Delegates in the shape of a ticket containing the names of the three members for the office of President-Elect and of one member for each of the other offices to be filled at the Annual Session."

To read:

"The committee shall report the result of its deliberations to the House of Delegates in the shape of a ticket containing the names of two or more members for the office of President-Elect and of one member for each of the other offices to be filled at the Annual Session."

By motion (Kosminsky-Ellis) the amendment was adopted.

The following proposed amendment to the by-laws of the society, introduced at the 1943 Annual Session and published twice in The Journal of the Arkansas Medical Society, was read by the secretary:

Proposed amendment to the By-Laws of the Constitution of the Arkansas Medical Society:

To amend the first sentence of Section 2, Chapter VI of the By-Laws which now reads:

"The President-Elect shall be a member ex-officio of the Council and the House of Delegates without the power of voting."

To read:

"The President-Elect shall be a member of the Council and the House of Delegates."

This is to conform with a previous amendment of the Constitution adopted last year which made the same change in Article VI of the Constitution.

My motion (Ketz-Dixon) the amendment was adopted.

A. C. Shipp discussed plans for medical societies to combat proposed legislation inimical to the best interests of the public and to the profession and presented the educational program adopted by the Arkansas Tuberculosis Association and suggested that the Auxiliary to the Arkansas Medical Society sponsor an essay contest for high school students, offering prizes for the best essays submitted. Another plan would be to offer a substantial prize to high school papers for a best edition. Such efforts would promote great interest and would develop great educational value, in the opinion of Dr. Shipp. Discussed favorably by McCaskill, Wolferman and others.

By motion (Barlow-Wolferman) a committee consisting of the president, the chairman of the council, the secretary, and Dr. A. C. Shipp was appointed empowered to act in this matter.

General discussion was held with Shipp, Hunt, Butts, Ware, Dixon, McDaniel, Ritchey, Moore, H. T. Smith and Norwood over the policy of

the State Board of Health in release of findings made at X-ray surveys throughout the state.

By motion (Kosminsky-McCaskill) the State Board of Health was requested to send the report of X-ray examination to the family physician, and where no family physician is named, to the local health officer.

The delegates from the respective councilor districts then met in caucuses and made the following selections for the Nominating Committee:

First District—J. H. McCurry.

Second District—W. J. Ketz.

Third District—J. O. Rush.

Fourth District—H. T. Smith.

Fifth District—A. D. Cathey.

Sixth District—L. J. Kosminsky.

Seventh District—W. G. Hodges.

Eighth District—Fred W. Harris.

Ninth District—D. L. Owens.

Tenth District—I. F. Jones.

The House of Delegates then adjourned.

SCIENTIFIC SESSION

Monday Afternoon, April 17th, 1:30 P. M.

The meeting was called to order by President Allbright at 1:30 P. M.

The invocation was given by Very Rev. Msgr. John B. Scheper, chaplain, St. Vincent's Infirmary.

O, God of infinite wisdom and understanding, fountain of all life, and holiness, and love, come unto us and be with us. Vouchsafe to enter our hearts; teach us what we are to do and whither we ought to tend; show us what we must accomplish, in order that, with thy help, we may be able to please Thee in all things. Be Thou alone the author and the finisher of our judgments. Suffer us not to disturb the order of justice, Thou who lovest equity above all things; let not ignorance draw us into devious paths, nor partially sway our minds, neither let respect of riches or persons pervert our judgment; but unite us to Thee effectually by the gift of Thine only grace, that we may be one in Thee and never forsake the truth. Inasmuch as we are gathered together in Thy name, so may we in all things hold fast to justice tempered by pity, that so in this life our judgment may in no wise be at variance with Thee and in the life to come we may attain to everlasting rewards for deeds well done.

Go before us, O Lord, we beseech Thee, in all our doings with Thy gracious inspiration, and further us with Thy continual help, that every prayer and work of ours may begin from Thee, and by Thee be duly ended. Through Christ our Lord. Amen.

Carl A. Rosenbaum, president, Pulaski County Medical Society, welcomed the members to Little Rock.

The Pulaski County Society is happy to welcome to Little Rock the members of the Arkansas Medical Society in its 69th Annual Session. I can assure you that we

look forward with much pleasure to this opportunity of greeting our friends from throughout the state. In our efforts to make this particular meeting a memorable one, please remember we miss very much the seventy members of our local society who are in the armed forces.

The fine work pertaining to health problems that has been done and that is being planned by the state society was very evident in the reports of the various committees this morning to the House of Delegates. The business of this organization is certainly going forward.

Possibly an apology is in order in regards to social entertainment. Those of you on a regular diet will not be inconvenienced but those preferring liquid nourishment will be a little disappointed. I might add that the time for celebration is not yet here.

May I say again that Little Rock is proud to have as its guests the Arkansas Medical Society.

J. S. Wilson, Monticello, responded to the address of welcome for the society.

Vice President B. L. Moore took the chair.

President Allbright read the annual President's Address (page 1).

President Allbright returned to the chair and the scientific program of the society proceeded in order.

"Surgical Management of Hernias"—H. E. Mobley, Morrilton.

"The Application of Fundamental Principles in the Treatment of Burns"—Neal Owens, New Orleans.

"Caudal Anesthesia"—I. F. Jones, Fort Smith.

"Cardiospasm: Its Medical Management"—Donovan C. Browne, New Orleans.

"Newer Methods of Treating the Mentally Ill"—N. T. Hollis, Little Rock.

Monday Evening, April 17th

The Pulaski County Medical Society entertained with a buffet dinner, reception and dance in the Marion Hotel honoring the members and visitors.

SCIENTIFIC SESSION

Tuesday Morning, April 18th

The meeting was called to order by Vice President Land at 9:30 A. M. and the program proceeded in order.

"A Brief Summary of the Modern Concepts of Acquired Syphilis"—E. J. Easley, Little Rock. Discussed by D. E. White, El Dorado, and C. W. Dixon, Gould.

"The Diagnosis and Treatment of Various Arterial Aneurysms"—R. M. Penick, Jr., New Orleans.

"Tumor Clinic of the University of Arkansas School of Medicine"—Carl A. Rosenbaum, Little Rock.

"Tuberculosis Control Program in Arkansas"—A. C. Curtis, Little Rock.

"How to Differentiate Emotional Glycosuria from Diabetes Mellitus"—L. N. Bollmeier, Hot Springs National Park.

MEMORIAL SESSION

Tuesday, April 20, 1944

The annual memorial session was called to order at 12 noon by President Allbright.

The invocation was given by Rev. S. F. Bryant, Pulaski Heights Presbyterian Church.

Mesdames Henry Franklin and E. Charles Eickenbaum sang "God Shall Wipe Away All Tears."

Mrs. H. T. Smith, McGehee, read the names of the deceased members of the Auxiliary.

IN MEMORIAM

Mrs. C. E. Spivey, Crossett, April 24, 1943.

Mrs. A. S. J. Collins, Monticello, May 30, 1943.

Mrs. Rufus Martin, Warren, December 13, 1943.

Mrs. R. H. T. Mann, Texarkana, December 13, 1943.

Mrs. J. W. Meek, Camden, January, 1944.

Mrs. W. H. Daubs, Foreman, January 1, 1944.

Mrs. S. B. Thompson, Camden, January 17, 1944.

Mrs. G. W. Ringold, Percy, February 2, 1944.

"Although these friends have gone from our earthly presence, death has not destroyed the beauty or influence of their lives. Our own lives are richer because we have known them and heaven is nearer to us because they are there.

While we, with unwilling fingers write the closing records of their lives on earth, the opening record of a new life beyond life is being made.

We should not mourn too much for those whose earthly life is ended but let the memories and the influence of their lives be an inspiration to us to live a more useful life, to higher hopes, a kinder spirit and a more trusting faith.

To their families and friends, we extend our deepest sympathy and our tenderest understanding, and pray that God will send peace to all who mourn.

May they find comfort in the words of Him who said: "I am the Resurrection and the Life; he that believeth in me, though he were dead yet shall he live."

President Allbright read the names of the deceased members of the society.

IN MEMORIAM

Lyle Gordon Young, Van Buren, April 19, 1943.

Leonard R. Ellis, Hot Springs, May 10, 1943.

William Jefferson Hutson, Eudora, June 20, 1943.

Meade B. Owens, Newport, June 20, 1943.

Tilden Paul Fowler, Harrison, July 5, 1943.

James Silas Kolb, Clarksville, August 9, 1943.

Cheves Bevell, Waldron, August 28, 1943.

Noble Jackson Hill, Hindsville, September 1, 1943.

John A. Moore, El Dorado, September 9, 1943.

Edward Rush King, Ashdown, September 24, 1943.

George Kellog Stephens, Newport, October 5, 1943.

Moses Green Daly, Little Rock, December 12, 1943.

Elbert Amsden Bing, Marshall, February 2, 1944.

Columbus Edgar Gannaway, Warren, March 5, 1944.

James Henderson Fowler, Harrison, March 10, 1944.

B. L. Ware, chairman, Committee on Necrology, gave the annual Memorial Address.

MEMORIAL ADDRESS

Once again, as we gather for annual session, we miss the friendly smile and hearty handshake of a number of our colleagues.

"Never yet was a spring time, when
the buds forgot to bloom,

Never yet was an annual session, but
that names are added in memoriam."

Now comes the hour on our program, so aptly and so fittingly established by our predecessors, to assemble and pay tribute and respect to the memory of those members who have passed since our last meeting, fifteen in number. By far the smallest number in my memory, and too, the Lord was gracious, since a large majority of these were permitted to live and labor to ripe old age.

"Flesh is but the glass, that holds the dust, that measures our time, which also shall be crumbled into dust."—George Herbert.

This is an hour of memories.

I realize my inability to speak words that would do justice to this occasion.

Certainly, I would not attempt to eulogize these fallen comrades; for too well they have left their eulogies indelibly stamped on the minds and hearts of those with whom they have lived, labored and loved. Death is sad; but death does not mean defeat; it means victory, to righteous men, as these men were.

We deeply sympathize with the members of their immediate families, and especially would we mention the doctor's silent partner, the wife or widow; to whose unassuming and untiring efforts go much of his professional success.

These good doctors, all members of the Ar-

kansas Medical Society, have served their respective communities well; not only as physicians but also as leaders in church, school and civic affairs. They have left behind them a heritage of duty and work well done. Sure we miss them, and are made sad to know that no more will we see their smiling faces and enjoy their hearty handclasp; no more will we be the recipient of their wise counsel and able assistance.

Their work here is finished. Their chairs are empty. They have gone to their eternal reward. But in their going they have left us a great challenge. Will we accept and will we keep the banner untrampled?

I feel sure if they could speak to us from that silent shore, they would remind us of our noble and glorious traditions, our unwritten laws and customs; and that we are to forever keep sacred these same ideals; that we are to care for all, rich or poor, high or low; that public good is to be preferred, rather than private gain; that what we are enjoying today is the result of another's labor; that selfishness will defeat our purpose, narrow our views and diminish our usefulness; that we are living and laboring in the most glorious age of our civilization. A time or an age I like to think of as an individual age, where we practice our art according to individual rights, free from political or bureaucratic influence; an age that has witnessed more advancement in medicine and its allied branches than since the birth of organized medicine; a time that the individual is his own, inspired to apply himself to attain knowledge, and to lead others. Competition is still the life of trade, as well as art or vocation.

Today the question is asked: Has American medicine failed in its mission, or does the record of its achievements warrant the belief that the rapid extension of medical care in this country has anticipated the need for drastic legislation, of any kind, much less S. B. No. 1161? Few will deny the enormous strides with which medicine has kept abreast of the rapid march of science during the last half century, not by political or bureaucratic leadership, but by individual initiative, individual energy and enterprise.

That American medicine is capable and willing to take care of its own house cleaning, if, as and when necessary, is demonstrated by the impressive elevation of the standards of medical education since the turn of the century. Even in my school days, medical diploma mills were rife, and in many of these institutions, the payment

of fees, rather than scholastic attainment, was the sine qua non for graduation. Yet, today, American medical schools are among the finest of their kind in the world. Too bad that recently the curricula has been shortened; or should I say standards lowered?

Equally significant advances have been made in extending medical care to middle income groups. Some eighteen plans have been sponsored or approved by medical societies in no less than fourteen states, with some twenty million subscribers. The enactment of the proposed Murry-Wagner-Dingell Bill might well sound the death knell of all such voluntary prepaid plans; and substitute a system of political medicine, which, with its vast financial resources, would dominate the practice of medicine in this country. Devolution would replace evolution, and American medicine would cease to attract to its folds the brilliant minds, which, in the past, have so successfully elevated its standards and added luster to its achievements. What would be gained if the extension of medical care in this country was attained by sacrificing professional standards of service which are today without a peer in the entire world? Now, to avoid such an eventuality, professional and public opinion must be stimulated and given direction through personal contact.

The profession seems fairly well informed. I hope and trust medicine still has an opportunity to mould public opinion. However, it remains for every member of the medical profession who cherishes the right to practice medicine the American way, to take time out and to talk with his neighbors, and give impetus to the surge of public opposition that has recently found expression in resolutions of important professional and business groups and in editorials in leading newspapers.

Finally, we pray, and may God grant us courage to withstand, the trials that face us in this war-torn, bleeding world; that soon hostilities will cease; that tyranny and cruelty will vanish from the earth, and be replaced by peace, lasting peace, for all mankind.

Mr. George Jernigan sang "The Lord's Prayer."

The benediction was given by Rev. S. F. Bryant, Pulaski Heights Presbyterian Church.

FINAL SESSION

House of Delegates

Tuesday Afternoon, April 18th

The meeting was called to order by President

Allbright at 1:30 P. M.

The secretary called the roll of delegates.

The following delegates and members seated as delegates by the House of Delegates were present:

ASHLEY—M. C. Crandall; BOONE—D. L. Owens; CARROLL—J. F. John; CHICOT—E. E. Barlow; COLUMBIA—J. H. Wilson; CRAIG-HEAD-POINSETT—L. H. McDaniel, J. H. McCurry; CRAWFORD—S. D. Kirkland; CRITTENDEN—B. M. Stevenson; DESHA—H. T. Smith; FAULKNER—C. A. Archer, Jr.; FRANKLIN—I. H. Jewell; GARLAND—A. H. Tribble, L. E. Reed, W. T. Wootton; HOWARD-PIKE—J. G. Waldrop; INDEPENDENCE—W. J. Ketz; LAWRENCE—J. C. Land; LINCOLN—C. W. Dixon; LITTLE RIVER—Norman W. Peacock; LONOKE—E. A. Callahan; MONROE—E. D. McKnight; OUACHITA—J. P. Clemens; PHILLIPS—J. W. Butts; PRAIRIE—J. C. Gilliam; PULASKI—Hoyt R. Allen, Fred W. Harris, C. A. Rosenbaum, C. M. Brooks, Paul Fulmer, J. A. Summers, Geo. Thompson, W. C. Langston; SALINE—L. J. Harrell; SEBASTIAN—I. F. Jones, S. J. Wolferman; SEVIER—R. C. Dickinson; UNION—B. L. Moore; WASHINGTON—Ruth Ellis Lesh, and WHITE—M. C. Hawkins, Jr.

Other members of the House of Delegates present were:

President Allbright; President-Elect Shuffield; Vice President J. C. Land; Past-Presidents E. E. Barlow, Geo. B. Fletcher, H. Fay H. Jones, L. J. Kosminsky, M. E. McCaskill, M. L. Norwood, R. B. Robins, H. T. Smith, S. J. Wolferman and W. T. Wootton; Councilors S. W. Douglas, L. T. Evans, J. G. Gladden, M. J. Kilbury, C. E. Kitchens, Clyde McNeil, J. O. Rush, S. A. Thompson and H. King Wade, and Secretary Brooksher.

L. J. Kosminsky presented the following report of the Nominating Committee:

President-Elect—C. A. Archer, DeQueen; S. W. Douglas, Eudora.

First Vice President—Hoyt R. Allen, Little Rock.

Second Vice President—H. E. Murry, Texarkana.

Third Vice President—Fred Hames, Pine Bluff.

Treasurer—Paul L. Mahoney, Little Rock.

Secretary—W. R. Brooksher, Fort Smith.

Councilor, Second District—L. T. Evans, Batesville.

Councilor, Fourth District—M. C. Crandall, Wilmot.

Councilor, Sixth District—C. E. Kitchens, DeQueen.

Councilor, Eighth District—M. J. Kilbury, Little Rock.

Councilor, Tenth District—Clyde L. McNeil, Rogers.

Delegate to the American Medical Association—S. J. Wolferman, Fort Smith.

Alternate to the American Medical Association—S. J. Allbright, Searcy.

S. W. Douglas was recognized and stated that he was overwhelmed with a sense of responsibility in his nomination. He stated that he felt the next two years would make major history in Arkansas. "I really feel incompetent to accept the responsibility. We have made so much progress in past years. We shall surely do as well in the future. This responsibility is on you. Organized medicine has lowered mortality and has given the United States the best health record in the world. I feel that we should resolve to better this wonderful record that has been made. Gentlemen, I am sorry to say that my affairs are such that I cannot accept the responsibility of this office. As sorry as I feel about it, I ask to withdraw my name as a candidate for the office of president-elect and take pleasure in moving that C. A. Archer be elected by a show of hands."

The motion was seconded by J. O. Rush and carried by upraised hands.

By motion (Shuffield-Hunt) the rules were suspended for the unanimous election of C. A. Archer as president-elect without ballot.

By motion (Owens-Middleton) all other nominees were elected unanimously.

C. A. Archer presented the report of the Reference Committee.

REPORT OF THE REFERENCE COMMITTEE

Your Reference Committee has reviewed all committee reports and the address of the President to the House of Delegates. The President's Address is well-prepared and shows careful thought. We especially wish to advise and urge that the members of the society aid and work with the blood plasma program. The Reference Committee suggests further study of the plans for a composite examining board before immediate and decisive action is taken.

We urge strenuous opposition to the Wagner Bill as well as to any other legislation which will tend to bring us state or federally-controlled medicine.

Without taking your time to read the list of the various committees, we wish to compliment the many committeemen for their careful work, and, as they have honestly devoted themselves to forming their recommendations, we offer no criticism and, therefore, whole-

heartedly recommend the adoption of all the reports as submitted.

Earle H. Hunt
C. A. Archer
A. S. Buchanan

By motion (Barlow-Dixon) the report of the Reference Committee was adopted.

Chairman McNeil read the report of the council.

REPORT OF THE COUNCIL

April 16th. Heard an appeal from the action of the Pulaski County Medical Society in denying membership. Voted to sustain the county medical society.

April 17th. Disapproved a composite medical examining board. Waived military dues. Made nominations for honorary membership. Accepted amendment from special committee on honorary memberships.

REPORT OF COMMITTEE ON HONORARY MEMBERSHIPS

We, your Committee from the Council, appointed to study the matter of honorary memberships in the state Society, beg to make the following report:

Throughout the past several years repeated discussions have come up in the House of Delegates and in the Council in regard to honorary memberships. Quite a few honorary memberships have been granted in the past few years and it was the opinion of quite a few of the members that some change should be made in the issuing of these honorary memberships.

There is one angle to honorary memberships that has probably been overlooked. Our By-Laws specify Roberts Rules of Order as a guide to procedure. This guide states that honorary members do not have the privilege of franchise. It appears that this would be just and right, for if they have the right to vote, they would have a tentative control of the disbursement of funds in which they have no financial interest. While we know that their vote would be perfectly safe it would require an amendment to the By-Laws to give them the right of franchise. We think it would be a friendly gesture for the state Society to issue an attractive certificate of honor to the physicians who have arrived at certain membership age.

Suggestions

All recommendations for life memberships must originate in the county medical society. Affiliate memberships should be granted if anyone of the following conditions have been met:

1. The physician is facing serious and prolonged illness.
2. He is in serious financial straits.
3. He is totally disabled.
4. He has retired from practice.

This group of physicians should be extended membership or waiver of dues which should be on an annual basis.

Summary

In summary two actions were suggested by this Committee. First, automatic life membership to physicians who have been in practice for 50 years and maintained continuous membership in the Society, or who has reached the age of 80 years; second, formal recognition in the Constitution and By-Laws for the waiver of dues.

PROPOSED AMENDMENT TO THE BY-LAWS RELATIVE TO DUES AND ASSESSMENTS

Resolved, that the By-Laws of the Arkansas Medical

Society be amended substituting the following:

"An active member who shall have attained his eightieth year and shall have been a member of his county medical society in Arkansas or elsewhere in the United States continuously since beginning the practice of medicine, or who for fifty years shall have been continuously a member of his county medical society in Arkansas or elsewhere in the United States, shall, upon establishing the above facts to the satisfaction of his county society, and upon the recommendation of such society, be granted the status of a life member. Such member shall enjoy full membership privileges and shall be exempt from the payment of further dues or assessments. An active member in good standing in his county society may, upon the recommendation of such society, be granted affiliate membership with full voting and other privileges where one or more of the following conditions exists; retirement from practice; physical or other disability of a character preventing the practice of medicine; a serious and prolonged illness; or financial reverses.

Affiliate membership shall be on an annual basis only and a member must be recommended each year for such special status by the secretary and president of his county medical society following a review and reassessment of his particular situation. An affiliate member shall enjoy full membership privileges and shall be exempt from the payment of dues and assessments during the year in which he is granted such status, and a certificate of membership shall be issued to him for such year.

H. T. Smith, Chairman
E. E. Barlow
S. W. Douglas

April 18th. Appointed committee to study state and county medical society constitutions. Suggested a poll of county societies on group health and accident insurance. Appointed committee to study medical practice acts.

By motion (Evans-Dixon) the report of the council was adopted.

C. A. Rosenbaum presented the following resolution:

Whereas, the public looks to the medical profession for leadership in matters involving the health of the people of the state and,

Whereas, the medical profession in general has long recognized the need of proper child spacing in selected cases, and

Whereas, The American Medical Association has endorsed the rendering by the medical profession, of information and advice concerning the prevention of conception; therefore,

BE IT RESOLVED: That the Arkansas Medical Society go on record as favoring the introduction of birth control for the indigent, and medically determined deserving cases, as a public health activity of The Arkansas State Board of Health.

M. C. Hawkins, Jr., moved adoption of the resolution and Fred W. Harris seconded the motion.

The resolution was discussed by Dixon, H. T. Smith, S. A. Thompson, W. C. Langston and M. C. Hawkins, Jr.

By a standing vote the motion was lost; 19 years, 24 days.

By motion (H. T. Smith-Wolferman) the fol-

lowing were elected honorary members:

Geo. Harrod, Conway.
J. R. Kitley, Mayflower.
S. P. Junkin, Little Rock.
C. E. Oates, North Little Rock.
R. Q. Patterson, Little Rock.
A. C. Shipp, Little Rock.
W. W. Verser, Harrisburg.
J. G. Watkins, Little Rock.
W. T. Wootton, Hot Springs National Park.

By motion (McNeil-Evans) the following honorary members were nominated for election to affiliate fellowship in the American Medical Association:

C. E. Oates, North Little Rock.
R. Q. Patterson, Little Rock.
A. C. Shipp, Little Rock.
J. G. Watkins, Little Rock.
W. T. Wootton, Hot Springs National Park.

By motion (Dixon-Ketz) the House of Delegates then adjourned.

FINAL GENERAL SESSION

Tuesday, April 18th

Immediately following the adjournment of the final session of the House of Delegates, the final general session was called to order by President Allbright.

The following past-presidents came to the rostrum: M. E. McCaskill, M. L. Norwood, W. T. Wootton, E. E. Barlow, H. T. Smith, L. J. Kosminsky, H. Fay H. Jones, S. J. Wolferman and R. B. Robins.

President Allbright: "Seated behind me are some of the past-presidents of this society. You all know them well. I will not attempt to introduce them."

R. B. Robins and S. J. Wolferman escorted Jos. F. Shuffield to the rostrum.

President Allbright: "It gives me great pleasure to hand you this emblem of authority in the Arkansas Medical Society. Nearly ten years ago you made your mark on me and now I am getting even in handing you this gavel, Joe."

President Shuffield: "I appreciate highly the honor you gave me one year ago today. I have had a whole year to think it over and to decide what I would say at this time but, as the time came nearer, I felt more humble and can only say that I shall do the very best I can. If you help me I can be a good president in the coming year. This coming year, I hope, will be Arkansas' greatest year. Our problems are many but let us hope that we do not get excited. If we

study them and do our best we shall successfully solve them. I ask you and I know I shall receive good honest hard work from all of you. Thank you!"

"I shall now ask S. W. Douglas, my good friend, to escort President-Elect C. A. Archer to the rostrum. Dr. Douglas has exhibited a wonderful spirit here this afternoon and deserves high commendation."

S. W. Douglas escorted President-Elect Archer to the rostrum.

C. A. Archer: "This is the greatest gratification I have ever felt. I joined this society a year or two after the first medical practice law was passed. It was a good law. It has been amended from time to time. Good men before us laid the good foundations for the betterment of organized medicine of today. I thank you for the honor you have given me."

By motion (Jones-Dixon) the society expressed its appreciation to the Pulaski County Medical Society, the Marion Hotel, the daily newspapers, and to the citizens of Little Rock for the courtesies and kindness accorded the society in this annual session.

H. Fay H. Jones extended an invitation for the society to meet in Little Rock in 1945 as guests of the Pulaski County Medical Society.

By motion (Kosminsky-Thompson) the council was authorized to designate the place of next meeting.

The several past-presidents then addressed the session.

By motion (Dixon-Thompson) the society adjourned sine die.

REGISTRATION

ARKANSAS—Arthur Fowler, E. B. Swindler, R. H. Whitehead; ASHLEY—M. C. Crandall; BENTON—L. O. Greene, Clyde McNeil, C. S. Wilson; BOONE—S. W. Chambers, J. G. Gladden, Lloyd Jackson, D. L. Owens; BRADLEY—W. J. Hunt, W. B. Reasons; CARROLL—J. F. John, D. K. McCurry; CHICOT—E. Baker, E. E. Barlow, J. H. Burge; CLARK—J. P. Bremer, J. T. McLain; CLAY—O. H. Clopton, F. H. Jones; COLUMBIA—L. Longino, J. H. Wilson; CONWAY—H. E. Mobley; CRAIGHEAD—POINSETT—Ira W. Ellis, J. H. McCurry, L. H. McDaniel; CRAWFORD—S. D. Kirkland; CRITTENDEN—L. C. McVay, B. M. Stevenson; CROSS—A. F. Barr, R. Longest, Thos. Wilson; DESHA—H. A. Rands, H. T. Smith; DREW—L. F. Billingsley, J. S. Wilson; DALLAS—A. M. Lisenbee; FAULKNER—C. A. Archer, Jr., A. S. J. Clarke, C. H. Dickerson, L. S. Dunaway, N. E. Fraser, Geo. Harrod, I. N. McCollum; FRANKLIN—I. H. Jewell; GARLAND—L. N. Bollmeier, B. F. Casada, G. C. Coffey, Geo. B. Fletcher, A. R. Power, John M. Proctor, L. E. Reed, A. H. Tribble, H. King Wade, W. T. Wootton; HOT SPRING—W. G. Hodges; HOWARD-PIKE—W. H. Toland, J. G. Waldrop; INDEPENDENCE—L. T. Evans, E. M. Gray, W. J. Ketz, J. T. Matthews; JACKSON—O. A. Jamison; JEFFERSON

—C. B. Capel, Fred Hames, J. S. Jenkins, M. A. Shelton, R. P. Woods; JOHNSON—Earle H. Hunt, J. M. Kolb; LAWRENCE—H. B. Hull, J. C. Land; LEE—C. W. Chaffin; LINCOLN—C. W. Dixon, S. W. Douglas; LITTLE RIVER—N. W. Peacock, E. W. Yates; LONOKE—S. S. Beaty, E. A. Callahan, S. A. Southall, A. C. Watson, Sr., J. B. Wells; MILLER—W. H. Daubs, Wm. Hibbitts, L. J. Kosminsky, B. C. Middleton, H. E. Murry; MISSISSIPPI—J. F. Brownson; MONROE—W. L. Boswell, E. D. McKnight; NEVADA—A. S. Buchanan, B. H. Pool; OUACHITA—J. P. Clemens, J. B. Jameson, B. V. Powell, J. S. Rinehart, R. B. Robins, R. R. Robins, S. A. Thompson; PHILLIPS—J. W. Butt, J. T. Herron, L. B. Jones, J. L. Ritchey, Jr., J. C. Moore; POLK—B. H. Hawkins; POPEYELL—W. E. Ballenger, Robert Hood, A. B. Tate, W. O. Young; PRAIRIE—Edward Adams, J. C. Gilliam, J. R. Lynn, T. G. Porter; PULASKI—Hoyt R. Allen, Jeff Banks, B. A. Bennett, R. W. Boyle, C. M. Brooks, T. Duel Brown, T. E. Burgess, F. Walter Carruthers, Hoyt Choate, A. C. Clark, J. M. Crawford, J. N. Compton, Bryce Cummins, Paul L. Day, E. J. Easley, Paul Eschweiler, L. L. Fatherree, P. M. Fulmer, S. C. Fulmer, Dewell Gann, Jr., Oscar Gray, W. B. Grayson, Fred W. Harris, C. R. Henry, H. Fay H. Jones, J. E. Jones, Glenn Johnson, N. T. Hollis, H. W. Hundling, M. J. Kilbury, A. C. Kolb, W. C. Langston, R. A. Law, Geo. V. Lewis, Paul L. Mahoney, C. B. May, Madeline Melson, O. C. Melson, Pat Murphey, M. E. McCaskill, W. V. Newman, C. E. Oates, J. E. Parsons, R. Q. Patterson, G. W. Reagan, L. D. Reagan, B. James Reaves, B. A. Rhinehart, D. A. Rhinehart, J. T. Rhyne, Carl A. Rosenbaum, T. T. Ross, R. E. Rowland, H. E. Ruff, W. L. Sadler, R. L. Saxon, W. J. Schwarz, A. C. Shipp, Jos. F. Shuffield, Randolph T. Smith, W. A. Snodgrass, Jr., A. R. Sparks, H. S. Stern, A. W. Strauss, J. A. Summers, P. E. Thomas, Geo. D. Thompson, E. I. Thompson, Chas. Wallis, V. T. Webb, E. Lloyd Wilbur, L. A. Wilcox; RANDOLPH—J. R. Loftis; SALINE—Dewell Gann, Sr., L. J. Harrell, Thos. S. Harris, C. W. Jones; SAINT FRANCIS—J. M. Roy, J. O. Rush; SEARCY—H. J. Hall; SEBASTIAN—C. E. Benefield, W. R. Brooksher, C. T. Chamberlain, J. S. Coffman, A. C. Curtis, T. P. Foltz, C. W. Hall, Chas. S. Holt, I. F. Jones, J. D. Riley, B. L. Ware, Carl L. Wilson, S. J. Wolferman; SEVIER—C. A. Archer, R. C. Dickinson, C. E. Kitchens, M. L. Norwood; UNION—A. D. Cathey, L. G. Fincher, David LeVine, B. L. Moore, E. J. Munn, P. H. Muse, M. V. Russell, D. E. White; WASHINGTON—Ruth Ellis Lesh, W. H. Mock, J. A. Robinson; WHITE—S. J. Allbright, A. J. Dunklin, M. C. Hawkins, Jr., A. H. Hudgins, J. A. Martin, D. W. Sloan, W. H. Wilson; WOODRUFF—E. F. Brewer.

Members, 229; Visitors, 38; Exhibitors, 34; Total, 301.

REPORT OF THE COMMITTEE ON MEDICAL LEGISLATION *

JOS. F. SHUFFIELD, Chairman

* Not presented to the House of Delegates.

The Legislative Committee has had nothing of importance to come before it for the past year. All the doctors are taxed with duties of capacity and beyond and little attention has been given to anything except to carry on with little time for meetings or legislative matters. Even in the few meetings that have been held our thoughts have been with our brothers who are nobly upholding the best traditions of our profession in the armed services, where we are not considering purely medical matters.

We have been doing more watching for the general interest of the profession than actual work.

We wish to call your attention of the profession at large that this is an election year and we should take time enough from our profession to see that good men are elected to the House of Representatives and the Senate. Also we should see that we have the best men possible for all other constitutional offices. This is highly important as the Legislature meets next year and no one can ever tell just what will come up and, from experience, we know that the better the men in the House and Senate the better will be the laws and the less we will have to fear of legislation that is unfavorable to the practices of medicine and the public.

No one has suggested any new legislation and I hope no one will suggest any. An old piece of legislation that has been with us in the past is the need of a composite examining board which heretofore has been considered not the best thing for us to undertake. Just a few more years and there will be no need for a composite board. Other branches of the profession than our own are slowly but surely becoming smaller and smaller and will finally play out. It has reached the point now to where it does not look possible for them to have enough strength to be any great problem.

There is one initiated act that is supposed to be coming in our general election this fall which will be of much concern to the profession. This is the Hollinsworth Hospital Act. This bill, if enacted, will be the most gigantic thing in the way of hospitalization that anyone could imagine and especially for a small, poor state like ours. This bill proposes:

To be offered to the people for adoption at the next general election, provides a comprehensive hospital system for the entire state. Apparently no such far reaching plan of hospitalization is in effect in any other state.

The system would be managed by a board of three members to be appointed by the Governor who will devote their entire time to the duties of their offices.

The Board is given authority to locate, construct, equip and operate all buildings of the system, the declared purpose being to make accessible general hospitalization for citizens of Arkansas, for the "balance of cost." Free service would be given indigents, but under a formula to be adopted by the Commission; others would pay according to the type of room or ward, and other factors.

The expenditures would seem to be rather staggering. There would first be erected, a medical research department, at a cost not exceeding \$500,000.

There would next be constructed, equipped and furnished complete for use, 5 general hospitals, each to cost not less than \$500,000.

After the 5 general hospitals are in operation, a county hospital shall be placed in operation in all the other counties which do not contain one of the general hospitals. The county units are to be emergency hospitals and clinics.

New taxes are provided for producing the necessary amount for construction and operation, and while the State Revenue Department collects all other state taxes, the hospital board shall collect all of the new taxes provided for the support of the system. These new taxes, which are in addition to all taxes now levied, are:

A tax on all timber, when severed, up to \$1 per M feet.

A tax of 6c to 11c per bbl. on crude oil, according to gravity.

A tax on natural gas, coal, ores, building stone and gravel. The tax on bauxite is fixed at 50c per ton.

A tax on soft drinks of 76c per gallon of syrup. Bottled

drinks, including beer, shall be taxed 1c for each 5c of the price.

A tax on chain stores, 1 or more of which is located in Arkansas. The tax ranges from \$50 to \$400 a store, and in addition an inventory tax is levied on the merchandise in the store. If a chain should consist of 50 or more stores, located outside of Arkansas, and they locate one of their stores in Arkansas, for that privilege, the chain would be taxed \$400.

A tax of $1\frac{1}{2}\%$ of the gross premium of all life, accident, health or casualty insurance, also carriers of workmen's compensation insurance. The tax on all insurance premiums was 2% until 1931, when this Society procured the passage of a bill increasing the taxes on life, health and accidents premiums to $2\frac{1}{2}\%$, the increase of $\frac{1}{2}\%$ to be deposited in the State Treasury to the credit of a new fund to be known as the "Sanitation fund of the State Board of Health." It provided that 25% of that revenue be used for the purchase of drugs and biologicals for the indigent sick. Your Society felt that there was a direct relationship between life and health insurance and the general health of the community, and that there was no injustice to the life and health companies in requiring them to contribute toward the improvement of the general health. This increase was imposed at the beginning of the depression, when the revenue for the benefits of the county health units was very meager, and this fund was largely instrumental in keeping them in operation.

A 10% tax on admission to "any place."

A tax of 8/10 of a mill on each kilowatt of electricity manufactured in Arkansas.

Several of these taxes are new, as for instance, the tax on soft drinks and chain stores, and the rate of nearly all other taxes are higher than those now prevailing, and all are in addition to all other levies. It is very improbable that the people of Arkansas by their votes, would impose any such rates as are suggested here. They would amount to an incredible sum, and it is doubted if the people would care to set up any additional taxing agency.

The legislative committee highly appreciates the effective cooperation they have received in the past from the profession at large and for reasons to be believed this will always be true and so long as we hold together we do not believe that anything could pull us apart.

AMERICAN TRUDEAU SOCIETY NEWS LETTER

The publicity which diasone received in various newspapers and magazines has led a great many tuberculous patients to believe that a drug is now available which will cure their disease. They are then very naturally demanding that this new and miraculous cure be made available to them, which places their physicians in a somewhat unenviable position.

Since most of our members have undoubtedly had to undergo this ordeal, it was the consensus of the Executive Committee that that part of the report of our Committee on Therapy dealing with diasone should be released forthwith,

rather than be held over for presentation at our annual meeting in Chicago.

"The Committee on Therapy of the American Trudeau Society (Medical Section of the National Tuberculosis Association) in session March 17 and 18, 1944, at Chicago and Waukegan, Illinois, has reviewed information so far made available to it on the effects of promin, diasone, promizole, diaminodiphenylsulfone and some related drugs upon previously established experimental tuberculosis in guinea pigs. It has also reviewed the very limited amount of roentgenological and clinical data from one institution so far made available regarding patients treated with one of the drugs; viz., diasone. On the basis of these data the following statement has been authorized:

"Promin, diasone, promizole, and certain related compounds appear to possess in varying degree the striking ability to restrain the development of experimental tuberculosis in guinea pigs. It is recognized that experimentally induced tuberculosis in guinea pigs offers many contrasts with clinical tuberculosis in human beings, even though the causative organism is the same.

"It is the opinion of the committee that the clinical and roentgenological data so far made available to the committee on the action of diasone in human tuberculosis is as yet inadequate both quantitatively and qualitatively to permit, even tentatively, a positive evaluation of its curative effects upon tuberculosis in humans. The committee believes that there is at this time no adequate basis for the optimistic implications of the magazine articles or of the releases to the press which are now so well known to both the profession and public. It is believed, on the contrary, that such implications are distinctly unwarranted and not in accord with the clinical evidence which has been reviewed by the committee. The committee regrets exceedingly that the magazine articles mentioned previously were published in spite of efforts on the part of both the committee and the clinician quoted to stop their publication.

"Until controlled studies of adequate scope have been reported it is recommended that none of these drugs be used for treating tuberculous patients except under conditions which will appreciably add to our knowledge of their clinical action, and in the presence of adequate facilities to protect patients effectively from their

potentially serious toxic effects. Patients and physicians must also be reminded of the provisions of the federal regulations which prohibit the distribution of a drug in the experimental phase of development to other than research institutions to which the material is assigned by the manufacturer for either laboratory or clinical investigations. The committee is informed that other clinical investigations are now in progress, and it is the expressed opinion of the committee that such further well-controlled clinical investigation is distinctly desirable.

"Any use of chemotherapeutic agents, including diasone, in the treatment of tuberculous patients must, therefore, be regarded as purely a project in clinical investigation. It must be again emphasized that such use is not without hazard and that the roentgenological and clinical evidence reviewed by the committee gives no justification at this time for any attitude concerning the value of these drugs in patients other than one of critical interest."

The foregoing report appears in the April issue of **The American Review of Tuberculosis** and has also been released to the National Tuberculosis Association and the American Medical Association for such publicity as they may deem advisable. Reprints of this report have been ordered from the **Review** and will be sent out on request as long as our supply lasts.

Very sincerely yours,

Cameron St. C. Guild, M. D.
Executive Secretary.

COMMUNIQUE

April 22, 1944

To the Editor:

I hope the shock of receiving this isn't too great. I've intended to write you for a long time and realize that I should have long ago, particularly after that message Mr. Hinton relayed to me.

There's been little change in my status in spite of the APO address which was put on during maneuvers down in the desert, where we fought valiantly against the 95th division.

However no campaign ribbons have been forthcoming though I felt like we deserved one after three months down there with the sand and C rations. It really wasn't so bad, not after the Louisiana maneuvers and I feel that I picked up some valuable knowledge, i. e., the exact dimen-

sions of a grease pit and deep pit latrine, and the exact time at which same should be covered. I haven't done much medicine though I've been my battalion dispensary for a year. I'm the only medical officer in the battalion, which is armored field artillery. I've picked up quite a bit of knowledge about the field artillery, however, and enjoy being up on the OP.

I was put on temporary duty at the Station Hospital on the orthopedic service shortly after our arrival here. Our medical officers were rotated through there at three week intervals to give us a taste of hospital work, and even though the time was short, I enjoyed the opportunity to see a few patients.

Living conditions are very crowded around here and I've been unable to find a place closer than Santa Barbara so I only get home about three nights a week because of gas rationing. It's a nice place to live, though, and I spent my leave there, mostly lounging on the beach, but I did manage to get into Los Angeles for a couple of days.

The Arkansas Medical Journal and the special armed forces edition have followed me faithfully in my various changes of station and I enjoy them very much and appreciate your efforts in forwarding them. I'll retract all previous statements about failure to receive The Journal, even though you do owe me six back issues for 1941.

Yours,

J. K. Thompson, Capt., M. C.
O-483022
Med. Det. 491st Arm. F. A.
Bn., APO 261
Camp Cooke, California.

COMMUNIQUE

May 6, 1944.

To the Editor:

I enjoy these papers and The Journal.

I have now returned to my permanent (?) station and so has my family. The trip to the overseas station was only temporary and concerning malariology. Also discovered a one-month-old promotion on my return to the United States.

Sincerely,

Harlan H. Hill, Capt., M. C.,
Borden General Hospital,
Chickasha, Oklahoma.

COMMUNIQUE

April 15, 1944.

To the Editor:

I wrote you a few days ago, but feel impelled to write you again. You mentioned that Sisco was somewhere in this area, and if you added one to the number of the Evacuation Hospital you gave me, you would be right. Anyway, I took the chance that it might be this unit here, that we are to relieve, and found Maj. Sisco. We had a fine, enlightening and interesting talk. His experiences here are so interesting that I want to tell you about them, knowing that he will not. It happened in December, and was written up in the newspapers, so it is not a military secret.

At 3 a. m. they climbed over the debarkation nets and into LCT's, and skimmed about the islands just off the peninsula, landing on a beach not far from where they are now. While the infantry were deploying up the land, they unloaded on the beach, when about 20 or 30 Jap planes peeled off a formation and bombed and strafed them. Major said they tried to crawl under their helmets with their entire bodies, feeling naked as hell during that affair. They lost men and officers during this. Then the navy, with cruisers, destroyers, and all sorts of ships, sent up a 30-minute barrage of fire from the three sides of the cape that made things so light you could almost read a newspaper. Sisco says that he did not realize the fire power of ships before. Then came the P-38s, P-47s, Fortresses, Liberators; wave after wave came in; bombers two or four abreast, fighters strafing, ten or more abreast, sweeping the area from the tip upward. The hospital set up their tents, but the Japs found them, and bombed and strafed them almost hourly for two days. They (?) slept in foxholes; any noise heard was fired at immediately. These land crabs here, some as big as footballs, would come noisily to the edge of the foxhole, and you'd cock your forty-five and wait to see whether a claw or a hand of a Jap appeared against the silhouetted sky. They stayed in their foxholes most of the time. Casualties were taken care of as best possible under fire, and the hospital dug out mostly underground, as it is now. Sisco relates the most interesting stories of blast injuries, and has a fascinating axiom about chest injuries. Plasma, morphine, the sulfonamides, early and radical debridement, excellent anesthesia (mostly sodium pentothal) kept mortalities low. He tells of Capt. Wick-

ard, who landed nearer the mainland with troops, and received the Silver Star for swimming about in the water nearly four hours, helping casualties aboard rafts and barges, giving morphine, sulfa drugs, bandaging, checking hemorrhage, etc., during particularly heavy fire. Sisco tells of a condition called war exhaustion, a nervous, jittery, sleepless condition caused by fatigue and nerve exhaustion, which is controlled by sedation with sodium pentothal and aided by seconal, nembutal, etc. The men, formerly evacuated when treated with narcotics, are now able to be sent back to combat soon.

Of course, things are quiet here now, comparatively speaking, and we go to work when our prefabricated hospital buildings are up. There is not much use in describing the insect and animal life here, you probably would not believe it. The malaria rate is low, the natives are of much better physical appearance than in New Guinea; sea life, such as shells, fish of all sorts, kinds, and colors are interesting, even to a land-lubber like me. Life is much like being a Boy Scout, only more so.

I thought you would like to know about Sisco and Wickard, if you do not already know; if you do, skip it. Sisco has certainly proved himself a worthy man, and a worthy surgeon; a man to be commended.

Please write when you can, for I am always glad to hear from you. You have no idea what a pleasure it is to get mail!

Sincerely yours, as ever,

John T. Monfort, Capt., M. C.

SUMMER DIARRHEA IN BABIES

Casec (calcium caseinate), which is almost wholly a combination of protein and calcium, offers a quickly effective method of treating all types of diarrhea, both in bottle-fed and breast-fed infants. For the former, the carbohydrate is temporarily omitted from the 24-hour formula and replaced with eight level tablespoonfuls of Casec. Within a day or two the diarrhea will usually be arrested, and carbohydrate in the form of Dextri-Maltose may safely be added to the formula and the Casec gradually eliminated. Three to six teaspoonfuls of a thin paste of Casec and water, given before each nursing, is well indicated for loose stools in breast-fed babies.

Please send for samples to Mead Johnson & Company, Evansville, Indiana.

CORRESPONDENCE

Dear Doctor:

The matter of new telephone service for sick persons confined to their homes and the request for such service by physicians is being brought to the attention of the Arkansas Medical Society. Today there are about 6,200 Arkansas persons waiting for telephone service and new installations must depend on the number of telephones taken out.

The provisions which you may like to know in connection with requests for your patients are:

New Service for Patients

Under Utilities Order U-2, new telephone service can be provided immediately only when needed in direct defense, public health, welfare or security. Other applicants, including cases of illness, may have to wait for from several weeks to several months for a new telephone.

Appeals

However, your patients who are seriously ill may appeal to the War Production Board for immediate telephone service. The appeal, accompanied by the attending doctor's statement of need for service, is made out and forwarded by the telephone company to the War Production Board in Washington. Whether or not the appeal is granted depends on the nature of the illness and why telephone service is essential. The fact of serious illness **alone** is not enough reason. **Your statement must make clear why the nature of the illness and its treatment require telephone service.**

Extensions

An extension telephone can be installed only temporarily in a patient's home, and only when the emergency need is confirmed by the doctor. When the emergency is over, Utilities Order U-2 requires that the extension be removed.

Careful consideration as to the actual **need** for telephone service before recommending it—and full information if the need is **certain**—will save time and trouble for you as well as the telephone company and the War Production Board.

The Southwestern Bell Telephone Company, which provided these facts, has expressed appreciation for the cooperation of the Medical Society and for the opportunity of asking our assistance.

The Southwestern Bell Telephone Co.

CORRESPONDENCE

May 1, 1944.

To the Secretary:

Your recent letter was received, and I wish again to express my appreciation for the privilege of attending the state medical meeting. I have attended several wartime meetings, and I must say that from my standpoint yours was an outstanding success, and the hospitality extended me I will not soon forget. May I extend to you and your society my best wishes for a very successful year.

With kindest regards, I am

Sincerely yours,

Donovan C. Browne, M. D.

COMMUNIQUE

May 1, 1944.

To the Editor:

Well, after being at Fort Sill for three months, I have been reassigned to the Post Surgeon's Office, Fort Sam Houston, Texas. So please change my address to that so I will continue to get The Journal.

I was all set to take a long trip over the waves, but at the last minute I was pulled out and sent back "Home."

I am sorry that I could not go overseas but since I could not, I am very happy to be back at Fort Sam.

Miles Kelly, Capt., M. C., is also here and Elmer Davis, Capt., M. C., Air Corps, is at Kelly Field.

My regards to all the gang.

W. R. Parsons, Capt., M. C.,
Post Surgeon's Office,
Fort Sam Houston, Texas.

COMMUNIQUE

To the Editor:

Thanks for Random Thots, President Allbright's and George Fletcher's letters. Really enjoyed them. "Someone must have torn off a piece" was passed around; afforded much amusement for American officers and enlisted personnel in this area. Most of the . . . officers got the point although it required a bit of explaining. Hospital here very busy as usual. At operation found a round worm obstructing the common bile duct! Expect to call on Capt. Causey soon.

R. H. Johnston,
Major, M. C.

COLOR FILMS

The motion picture in color, "Continuous Caudal Analgesia in Obstetrics," which was made available by Eli Lilly and Company, Indianapolis, for showing before medical societies and hospital staffs, has been in continuous demand since release several months ago. It was made at the U. S. Marine Hospital, Staten Island, by authorization of the Surgeon General, U. S. Public Health Service, and the demonstrations were carried out by Drs. Hingson and Edwards, originators of the technic.

The three films that were made at the Nutrition Clinic of the University of Cincinnati in the Hillman Hospital, Birmingham, Alabama, under the joint auspices of the Department of Internal Medicine at the University of Cincinnati and the University Hospitals of Cleveland have likewise been in constant circulation. One of these deals with thiamin chloride deficiency, one with nicotinic acid deficiency, and the third with ariboflavinosis.

None of the films contain advertising. They are available to physicians for showing before medical societies and hospital staffs.

COMMUNIQUE

April 11, 1944.

To the Editor:

Your welcome V-mail of March 20th arrived yesterday. You will please note the change of A.P.O., which represents a damned uncomfortable move from * * * to another island in the * * *. Will be here some time, we expect, but nothing ever happens in the army that doesn't get worse! E. G., land crabs as big as footballs convene in your tent when dark; rats and mice even nip your toes through the mosquito netting; lizards stare down at you from the top of your netting; a silvery worm, living in cocoanut palms, secretes a blistering fluid. Sounds trying—and IT IS! Am doing well, physically speaking, however. We are relieving an underground hospital here.

Best regards,

J. J. Monfort, Capt., M. C.

COMMUNIQUE

May 3, 1944.

To the Editor:

I finally have received "Random Thots" after it has followed me silently over the East. I'm not sure which monthly edition it is, but any news from Arkansas is welcome to these sore eyes.

I'm going to propose a campaign ribbon decoration for the Southern boys living among the Yankees during the war.

I enjoy The Journal very much and please continue it. The above address is my permanent one as far as I know.

Sincerely,

Lt. Leslie G. Holt, M. C.,
Med. Detach. Recep. Center,
Fort Dix, New Jersey.

COMMUNIQUE

To the Editor:

Your attention is invited to the change in APO number of the writer (if you please, but that is not military), who desires to get the official publication of the Society.

For your information the writer now has been made officially the base surgeon of this base. The base is a cow pasture. So now that he is the base surgeon of a cow pasture, he feels that some scientific publication should be laying around on his feed box desk.

Naturally there will be no thanks for this, but for the authorization for compliance with this request you may select any available regulation.

In this cold damp climate, your letter received today you may be sure was warmly appreciated. Please continue my mailing address on the list for future contributions, and thanks.

Respectfully (and that ain't right),

Jett O. Scott, Major, M. C.

COMMUNIQUE

March 23, 1944.

To the Editor:

I was certainly glad to receive your most welcomed letter. It was very kind and thoughtful to make the effort to locate me. It would certainly be a pleasure for me to receive The Journal of the Arkansas Medical Society and your monthly letter. I hope everything is doing well in the States and trust when this is all over with we can get together for a better nationwide organization.

I have not contacted but one Arkansas doctor over here, Capt. Evan Houston, of Hot Springs, but understand they are all doing well in our armed forces all over the world. I will be looking forward to receiving my Journal and letters. Again thanking you very much.

Sincerely,

Vincent M. Cox,
Capt., M. C.

WOMAN'S AUXILIARY PAGE



MRS. A. C. SHIPP

Little Rock

President, Woman's Auxiliary to the
Arkansas Medical Society
1944-1945

New officers of the Sebastian County Medical Society Auxiliary were installed at a luncheon May 8th, standing committee appointments were announced, and at the end of the business session meetings were suspended for the summer.

The new officers are Mrs. B. L. Ware, who succeeded Mrs. W. F. Rose as president; Mrs. Rose, vice president; Mrs. S. P. Stubbs, secretary; Mrs. W. G. Eberle, treasurer.

The personnel of committees named follows:

Public relations, Mrs. M. E. Foster, chairman, Mrs. A. A. Blair, Mrs. Thomas P. Foltz, Mrs. Kenneth Thompson, Mrs. Fred Krock; Hygeia, Mrs. J. L. Kellum, chairman, Mrs. B. B. Bruce, Alma, Mrs. Minnie U. Fuller, Magazine, Mrs. S. P. McConnell, Booneville; telephone, Mrs. Ralph Crigler, Mrs. W. F. Adams, Mrs. D. W. Goldstein; program, Mrs. J. S. Southard, Mrs. Walter G. Eberle, Mrs. C. S. Means; health, Mrs. Everett C. Moulton, Mrs. Mabel Wood Scott, Mrs. C.

S. Holt, Mrs. A. F. Hoge; courtesy, Mrs. Charles T. Chamberlain, Mrs. J. E. Stevenson; legislation, Mrs. W. R. Brooksher, Mrs. H. H. Smith, Mrs. H. C. Dorsey; Mrs. G. G. Wood, Huntington; publicity, Mrs. W. F. Rose; cancer control, Mrs. S. J. Wolferman, Mrs. W. R. Brooksher, Mrs. C. E. Hall, Greenwood, Mrs. Merle Wood, Huntington.

Mrs. W. R. Brooksher, Jr., essay chairman, reported on the 1943-1944 contest in which Bobby Dick Bramhall and Lois Ann Paddock were winners of first and second places, respectively, in the local contest; and Bramhall was winner of third place in the state contest. The essay subject was, "Medicine at the Crossroads."

 COMMUNIQUE

March 31, 1944.

To the Editor:

The "Service News Letter" for March has just been received here. Allan Russell and I have really pored over the news. You've no idea how much those of us in the far corners appreciate hearing from friends at home. We are at present somewhere in * * * and, contrary to all expectations, are really enjoying it. Our climate is much like that of Little Rock in August with one exception, we get a cool breeze every night that makes sleeping a delight—you can imagine how much Russell appreciates that.

So far our hospital has developed into a darn good bunch of engineers. You should have seen the Docs on the heavy end of a jackhammer trying to dig latrines in hard coral. It has been a real experience but we are looking forward to the time when we can be doctors again. Ran into Monty Monfort of Batesville the other day and the tropics don't seem to have changed him a bit with the exception of the loss of six inches of waistline.

We can't tell you much of the medical problems here since that is still classified as information of military importance but, suffice it to say, the internists have had a field day, and the surgeons languish in high dudgeon.

Please keep the news and The Journal coming this way. Again I say you have no idea how much we appreciate it.

Louis K. Hundley, Capt., M. C.

COMMUNIQUE

To the Editor:

Thanks, my friend, for the nice letter that came this week. It and The Journal reflect a nice job that you are doing in getting in touch, and keeping that touch, with the boys.

The added note to the letter has been the rounds of one building here, and is now starting on the annex, and is being enjoyed by all of us. Here is one that I saw somewhere in the fog—you may have seen it long ago:

A SECRET

He grabbed me by my slender neck,
I could not call or scream.
He took me to his darkened tent
Where we could not be seen.

He tore from me my flimsy wrap
And gazed down on my form,
I was so scared, so cold, so damp,
And he so nice and warm.

His fevered lips he pressed to mine,
I gave him every drop.
He took from me my very soul,
I could not make him stop.

He made me what I am today.
That's why you find me here.
A broken bottle thrown away
That once was full of beer.

I really enjoyed the meeting that you fellows had. There were some most timely subjects brought to the attention of all of us, and many thanks to you and the other men that put it together. The two most timely were: The paper on arterio-venous fistula, and Hollis' discussion of the psychiatric problem. If we don't get more men saner minded on anxiety states, we are going to be confronted with a neurosis in our returning soldiers that has been unheard of to date. We are told that we are faced right now with * * * per cent of our men that are wholly unfit for duty, and with that and this invasion of bureaucrats over the whole nation, we had better start now to rebuilding our population, physically, for the next world tragedy, and that will be along in another 25 years.

Thanks again, for a grand meeting, and best regards to you all.

Sincerely,

Byron A. Bennett, Maj., M. C.,
Army and Navy Hospital,
Hot Springs, Ark.

COMMUNIQUE

April 21, 1944

To the Editor:

I received your "Random Thots" today (March edition). No doubt it caught a slow freighter. I do believe some of my air mail reaches me via freight. What happens in the interim from time it's mailed (posted over here) is' anyone's guess. Not bad considering the number of troops overseas.

Have been here in * * * long enough to have seen many historical places of interest. * * * is quite a city. Never have enough time while visiting there. This * * * weather reminds me of dear old "Sunny Calif." you know, San Francisco fog, etc. In spite of that, the country is beautiful. I have been in some homes for cocktails and dinner, which I thoroughly enjoyed. Scotch a bit hard (?) to find, but gin rather plentiful. Just finished course in combat neurosis with honest-to-God patients. Am sending separately "Yank" and "Stars and Stripes." Do you have any APO's of anyone over here? Like to see some Arkansas fellows.

Sincerely,

James W. Branch, Lt. Col., M. C.

BOOK REVIEWS

Fractures and Dislocations for Practitioners: By Edwin O. Geckeler, M. D. 3rd Edition. Pp. 361. 320 illustrations. Price \$4.50. Baltimore: Williams and Wilkins, 1944.

This is a fundamental text with treatment concisely presented. Recourse has been had to current literature for the newer procedures developed in the war theatres and on the industrial front. It is well-written and offers the busy practitioner a modernized text on fractures, dislocations and their care without unnecessary discussion.

Minor Surgery: By Frederick Christopher, S. B., M. D., F. A. C. S. Associate Professor of Surgery at Northwestern University Medical School, Chicago; Chief Surgeon at the Evanston (Ill.) Hospital. Pp. 1006. The Fifth Edition is reset with 575 illustrations. Philadelphia and London: The W. B. Saunders Company, 1944. Price \$10.00.

Should a physician's library be limited to but two books, Christopher's Minor Surgery certainly should be one of them. The doctor just entering practice will find this the most valuable book he ever used. The simplicity and clarity of its many illustrations are not surpassed. No words are wasted in argumentative discussion and theory. It is full of invaluable hints on diagnosis of every-day minor surgical conditions and the treatment is explained simply. For reference it is seldom found lacking and it is so readable that one is tempted to not lay it aside until it has been completely perused. The sections on varicose veins, local anesthesia, infections, and treatment of wounds are classical. In the fifth edition new material includes local use of sulfonamides, penicillin, plaster casts in wound treatment, preoperative and postoperative care, shock

and its treatment with blood, plasma and other agents, and the employment of intravenous anesthesia.

Typical of its scope and "horse sense" are the following two examples: For control of epistaxis a rubber finger cot is inserted deep into the nose. This prevents mucosal irritation when gauze is packed into the lumen of the cot and moistened with water. To remove a fish hook the barb of which has entered one side of the finger and exited from another, rather than make an incision, the hook is severed with wire cutters near the point of entry and the embedded part easily pulled on through as would be a curved needle.

Traumatic Injuries of Facial Bones: By John B. Erich, M. S., D. D. S., M. D., Consultant in Laryngology, Oral and Plastic Surgery at the Mayo Clinic, Assistant Professor of Plastic Surgery, The Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota; Diplomate of the American Board of Plastic Surgery; and Louie T. Austin, D. D. S., F. A. C. D., Head of Section on Dental Surgery at the Mayo Clinic, Associate Professor of Dental Surgery, The Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota. In Collaboration with Bureau of Medicine and Surgery, U. S. Navy. 600 pages with 333 illustrations. Philadelphia and London: W. B. Saunders Company, 1944. Price \$6.00.

This is an excellent text on general considerations of the subject with conservative suggestions for treatment of the traumatic injuries of the bones of the face. The judicious use of illustrations amplifies the concise descriptions.

Fundamentals of Neuropsychiatry: By Lowell S. Selling, ScM., M. D., Ph. D., Dr. P. H. Director, Psychopathic Clinic, Recorder's Court, Detroit, Michigan; Associate Attending Neuropsychiatrist, Eloise Hospital; Adjunct Attending Neuropsychiatrist, Harper Hospital. Pp. 500. St. Louis: C. V. Mosby Company, 1944.

This volume is what it implies: A synopsis of the subjects of neurology and psychiatry combined into one small book. It is, really, a simplified outline of these subjects. It is especially useful to students in reviewing for examinations and for the busy general practitioner who does not have the time for extensive reading on these subjects. It will prove a very useful book, not only to the student but to those physicians who are interested in these branches of medicine.

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Gastro-Enterology: By Henry L. Bockus, M. D., Professor of Gastro-enterology, University of Pennsylvania Graduate School of Medicine. In three volumes, totaling about 2700 pages with about 900 illustrations, many in colors. Volume II—"Intestines and Peritoneum." 975 pages with 176 illustrations—12 in colors. Philadelphia and London: W. B. Saunders Company, 1944. Price—3 Vols. and separate desk index, \$35.00.

The second volume of this text discusses diseases of the small intestines, the colon, the peritoneum and the omentum and mesentery. This volume well justifies the reviews of the first volume in the series bringing down to date the vast amount of work which has been done on diseases of the digestive tract, written in detailed manner from the author's wide experience.

Traumatic Injuries of Facial Bones: By John B. Erich, M. S., D. D. S., M. D., Consultant in Laryngology, Oral and Plastic Surgery at the Mayo Clinic, Assistant Professor of Plastic Surgery, The Mayo Foundation for Medical Education and Research, Graduate School, University of

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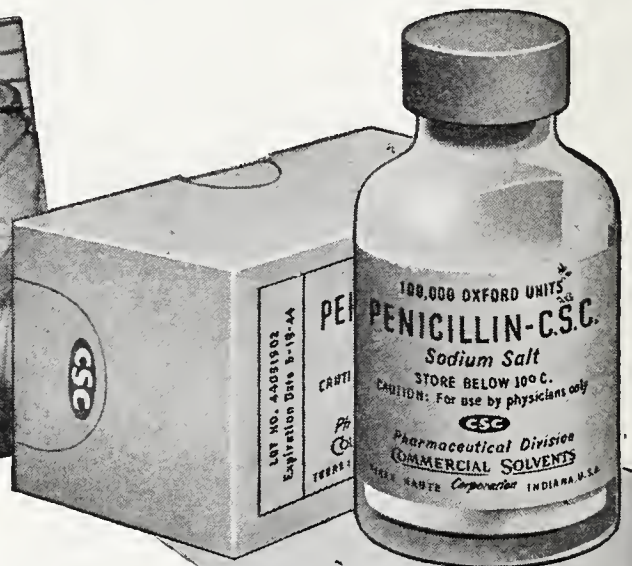
A. L. CORNET, M. D., Department Director

LINCOLN HIGHWAY—29 MILES FROM CHICAGO LOOP

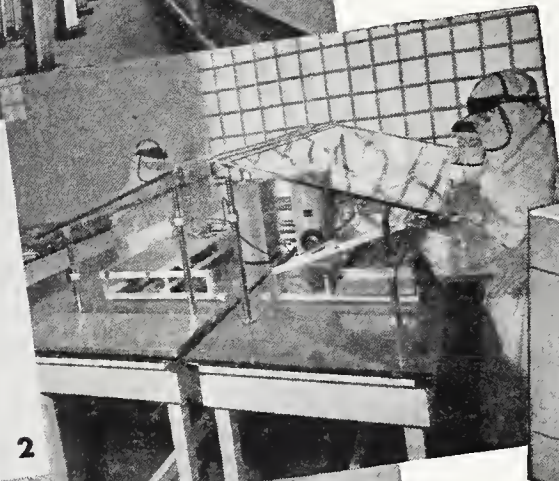
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1

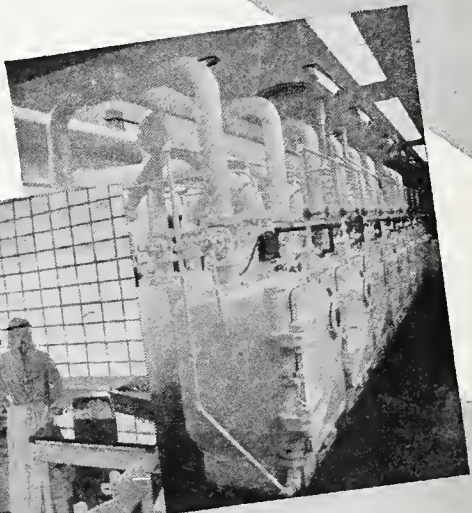


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facial shields which carry the technician's breath away from the work area—

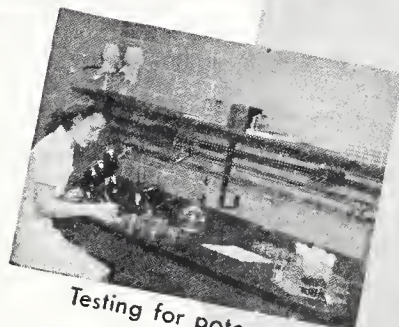
these are but a partial list of the safeguards employed in the "sterile area" of the C.S.C. plant.

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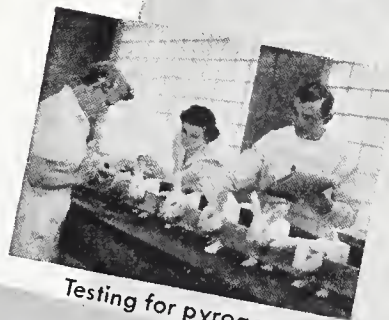
Penicillin-C. S. C., now allocated as the armed forces direct, will be available in adequate distribution throughout the country as soon as released.



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Minnesota; Diplomate of the American Board of Plastic Surgery; and Louie T. Austin, D. D. S., F. A. C. D., Head of Section on Dental Surgery at the Mayo Clinic. Associate Professor of Dental Surgery, The Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota. In Collaboration with Bureau of Medicine and Surgery, U. S. Navy. 600 pages with 333 illustrations. Philadelphia and London: W. B. Saunders Company, 1944. Price \$6.00.

This is an excellent text on general considerations of the subject with conservative suggestions for treatment of the traumatic injuries of the bones of the face. The judicious use of illustrations amplifies the concise descriptions.

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No. 2

TUBERCULOSIS CONTROL IN ARKANSAS*

A. C. CURTIS, M. D.

Little Rock

In the United States prior to the present century, no organized or concerted control of tuberculosis had been attempted. In 1890 the State of New York recognized this problem as one devolving largely on the state and as a result of a report and recommendations made by Dr. Herman M. Biggs, the New York City Health Department worked out a basis for a local program for the control of tuberculosis. This was the initial step in this nation for the administrative control of tuberculosis by formal government agencies.

In Arkansas, the problem was first seriously attacked in 1908 when the Arkansas Medical Society recommended the establishment of the Arkansas Public Health Association. This association was quite effective in influencing the legislature to appropriate funds for the establishment of the sanatorium at Booneville. This original body went through several subsequent changes and has finally become known as the Arkansas Tuberculosis Association. In 1913 the legislature provided for the setting up of the State Board of Health but no definite portion of this body was devoted to the control of tuberculosis until 1938 when a Division of Communicable Diseases was established and having as one of its parts the subdivision of tuberculosis control. The functions of the latter have become so important that it is now assigned to the rank of a full division. Thus, through the years a gradual organized program for the control of tuberculosis has been evolved and which consists today of four principal groups: The State and County Tuberculosis Associations, composed of laymen; The Medical Profession; The State Sanatoria and the Division of Tuberculosis Control of the State Board of Health.

Much has been accomplished in the control

of tuberculosis as the death rate for the nation as a whole has dropped from 254 per 100,000 in 1890 to 43.5 per 100,000 in 1942. Of course this remarkable drop is not due entirely to the efforts of the above mentioned groups but they have served in the control of tuberculosis such as no other body could possibly do.

Tuberculosis is a preventable disease and, therefore, a control program should exist in every community. In this respect, Arkansas has been among the leaders in the South. Our state rate is 50.5 deaths per 100,000 as compared to an average rate for the United States of 43.5. We are here, confronted by a large Negro population, a relatively sparsely scattered agricultural population, and a large area in square miles over which this program must be effected.

Control of tuberculosis has been attempted by three broad avenues of attack: (1) The education of the general population as to just what tuberculosis is, how it is spread, how it may be cured, and how to protect one's self from the disease; (2) Early diagnosis and treatment; (3) Rehabilitation of the ex-patient.

It is a happy fact that the relationship of all the agencies cooperating in the control of tuberculosis in the State of Arkansas has been a pleasant one and all of these agencies are harmoniously working together to the end that tuberculosis will cease to be of any importance as a public health menace. There is so much work to be done that there is a place for every recruit interested in the control of tuberculosis.

The educational activities have been carried on largely by the Arkansas Tuberculosis Association and the local county tuberculosis associations. This group is active in the distribution of literature, the securing of space for newspaper articles, radio broadcasting, lectures before interested groups such as P.T.A.'s, civic bodies, colleges and schools. The tuberculosis associations also sponsor tuberculin testing clinics and have actively cooperated with the state health officials in counties in which the state had no local representation. In addition the Arkansas Tuberculosis Association furnishes free Old Tuberculin to any private practitioner who requests

* Read before the Sixty-Ninth Annual Session, Arkansas Medical Society, Little Rock, April 18, 1944.

it. These activities are made possible by revenues derived from the sale of Christmas Seals. Numerous motion picture films relating to tuberculosis are available for showing, both by the Arkansas Tuberculosis Association and the State Health Department. It is felt that the education of the public is probably one of the most important phases in the activities of any group attempting to control tuberculosis, for it is only by such means that an understanding can be effected in the people's minds and a whole-hearted cooperation with the medical profession brought about.

Early diagnosis and treatment are almost entirely in the hands of the medical profession, the State Sanatoria and the State Health Department. Those of us who deal daily with tuberculosis always have in mind two principles: (1) That one case of tuberculosis always comes from another case of tuberculosis and (2) that if a patient waits to present himself to the examining physician until he, the patient, knows that there is something wrong, then that case will be moderately advanced or far advanced when initially diagnosed. These two principles have as their corollary that once a case is diagnosed the source of that infection should be looked for always. A positive tuberculin reaction in a pre-school child or six- or seven-year-old child should always institute a case finding program in that child's family. The development of a case of reinfection tuberculosis in a young adult should occasion an inquiry into his immediate contacts, both family and business. The second principle demonstrates that instead of the patient coming to the doctor for a diagnosis, the diagnosis will have to be taken to the patient. More and more emphasis is being placed upon the tuberculin testing and X-raying of apparently normal individuals, especially in the age group of 15 to 45, and it is in this group that tuberculosis still causes more deaths than any other disease. If this fact is kept in mind by the physician, he will become more tuberculosis conscious. Obviously the man working with tuberculosis as a specialty thinks first of tuberculosis. Unfortunately the private practitioner has so many varied problems to occupy his mind that the thought of tuberculosis does not enter his mind quite as readily as it should. The present emphasis being placed on tropical diseases, industrial injuries and war injuries is too prone to divert one's attention from an ordinary everyday occurrence which has existed in this country for years. If one stops to consider that in three years' time tuberculosis kills more people than casualties have been suf-

fered by all the armed forces of the United States since Pearl Harbor, it is evident that it behooves the physician to, at all times, keep tuberculosis in the fore part of his mind. Unless a practitioner is quite well acquainted with the family he may be rather reluctant to insist upon the examination of an entire family when a case of tuberculosis is discovered. It is the duty of the public health officials to cause such examinations to be done when a case of tuberculosis is reported. Obviously until such a report is made the official health agency may be entirely unaware of the new case. Tuberculosis is classed as a reportable communicable disease and the medical profession is urged to cooperate with the agencies by better reporting of all cases discovered by them.

Arkansas is fortunate in having two modern and well equipped state-owned sanatoria; the Arkansas Tuberculosis Sanatorium at Booneville with a bed capacity of 1,200 and the McRae Memorial Sanatorium at Alexander with a bed capacity of 200. These institutions afford the latest and best therapeutic procedures known to the medical profession in the treatment of tuberculosis. They render an added service by acting as consultants to the private practitioner and in the performance of diagnostic out-patient examinations. The facilities at Booneville are adequate for the time. The bed capacity and trained personnel at the Negro sanatorium is woefully lacking. One of the first constructive moves after the wartime restrictions are lifted should be the addition of at least 300 beds to the Negro sanatorium and the establishment of a trained staff. The Negro in Arkansas presents a discouraging picture in that even after a diagnosis is made no treatment facilities are available for him. There are at the present time, some 600 cases on the waiting list for admission to the McRae Sanatorium, and in all probability a majority of these patients will die before sanatorium care can be offered them. In any event, most will certainly be hopelessly far advanced cases before admission. These two institutions have materially aided in the control of tuberculosis by selecting the case with a positive sputum, which is yet amenable to treatment, for admission. Thus, a definite source of contagion is immediately removed from the public, an arrest is effected, and that person prevented from becoming a hopelessly far advanced case, free to spread tubercle bacilli to everyone with whom he comes in contact. The sanatoria are also used in some instances as a means of isolation for hopelessly far advanced cases where the

family living conditions are poor and a number of young persons would be thrown in close contact with the patient.

The Division of Tuberculosis Control of the State Board of Health has devoted its activities largely in the direction of early diagnosis. This has been done by the organization of diagnostic clinics by the local county health departments in which histories are taken and persons X-rayed by means of the state-owned mobile X-ray unit. The department has been limited to one 35-mm. photo-fluographic machine by wartime restrictions but another has been ordered and delivery is expected the latter part of June. During the year July 1, 1942, to July 1, 1943, 82 clinics were held in 52 counties and 15,532 chest films made. On the basis of these films 486 new cases were discovered. Largely through funds furnished by the county tuberculosis associations, 1,878 films were made by private practitioners and sent in to the central office for interpretation. One hundred sixty-seven new cases were discovered in this group. Thus, this department was instrumental in discovering 653 new cases of tuberculosis and referring them to their family physicians. It is anticipated that during the year 1943 and 1944, some 25,000 X-rays will be made by means of the portable X-ray machines.

The sanatoria have cooperated with the Division of Tuberculosis Control in the notification of patients on leaves of absence and of cases returned home because of a hopeless condition. In the care and instruction of such cases and in attempting to see that the patients avail themselves of the care offered them, 13,779 home visits were made by the nurses of the Health Department. During the past year, upon the approval of the Arkansas Medical Society, the Division of Tuberculosis Control entered into an industrial survey. This program has, of necessity, been limited because of lack of equipment but it is hoped to expand this into a real service. For the first time, X-rays were offered to all the students of all the colleges in the State of Arkansas. Every college participated in this program and the vast majority of the students were X-rayed. The inmates and personnel of most of the state institutions were X-rayed, notably the State Hospital for Mental Diseases, the state penal institutions and the Boys' Industrial School.

A system of reciprocal notification is carried on between the state and the Veterans Administration, Selective Service and other State Health Departments. A pronounced effort has

been made to see that all selectees rejected because of chest conditions have follow-up examinations by their family physicians and are placed under proper treatment. The films of all the selectees rejected because of tuberculosis are filed alphabetically in the Division of Tuberculosis Control and are available for comparison with subsequent pictures.

The problem of rehabilitation has been handled largely by the sanatoria and the county health departments working in conjunction with the vocational rehabilitation division of the State Department of Education and the State Welfare Department, while the patient is being rehabilitated. The Vocational Rehabilitation Department, after a consultation with the patient, makes plans for the patient to receive instruction in a new line of useful endeavor which would fit him to resume his place in society. This is an especially important activity in an agricultural state, as few persons, once having had far advanced tuberculosis, will ever again be able to stand up under the physical strain of farming. Here again, the tuberculosis associations have offered financial assistance in the securing of such training. Such a well directed program may be the means of restoring a discouraged patient's self-confidence and enable him to again become self-sufficient and remove his dependents from charity rolls.

Now as to future plans, it is hoped that a total of four mobile X-ray units may eventually be procured. Application has been made to the Commonwealth Fund for a \$16,000 unit and this is to be acted upon in 1945. By means of such equipment a diagnostic clinic could be held in each county, at least once in every two months. The Arkansas Tuberculosis Association is lending the state a vehicle for transporting the new machine which is too large to carry in an automobile.

The passage by the last legislature appropriating \$15,000 yearly for the payment of pneumothorax treatment assures that no charity work of this kind need be done. However, many communities do not have a fluoroscope available so that even though competent medical men are in that section, patients are forced to go many miles for their pneumothorax refills. It is planned to establish fluoroscope installations in areas lacking such facilities which would be available to the private practitioners for the administration of pneumothorax to their patients.

An accurate census of known cases of tuber-

culosis is an excellent step in a control plan. From this can be derived a complete list of those who have been in close contact with tuberculosis and case finding in this group results in the very earliest diagnosis of tuberculosis.

A feasible plan on a state-wide basis has been perfected by the U. S. Public Health Service just this year. An effort will be made to institute such a case registry for the state. In addition the National Tuberculosis Association has set up a plan for a central registry on a county level. Such a register is to be started soon in Pulaski County and it is hoped to institute similar ones in the counties of the state which have active health departments.

Many states are now having courage enough to tackle a problem of the recalcitrant chronic open case of tuberculosis who repeatedly leaves the sanatorium against medical advice and who is a distinct public health menace. These states have passed legislation which enables the public health authorities to require such an individual to take treatment. Such a program can not be started in Arkansas until both suitable legislation and suitable hospitals for such persons can be prepared. It is hoped that with the acquisition of additional equipment by the State Health Department that legislation may be passed requiring a chest X-ray of all school teachers and food handlers as a part of their already required health certificate. A teacher with tuberculosis or a servant in the home with tuberculosis is of infinitely more danger to their contacts than is one with most forms of syphilis, yet the greatest emphasis is placed upon a negative blood serology and little or no attention paid to such an individual's lungs. A better planned program of education is contemplated with a special emphasis on schools and industries. It is thus felt that a greater participation in the control of tuberculosis will result from a concentrated long range program in these groups.

The editorial comment prefacing the Tuberculosis Abstracts in the April issue of the Arkansas Medical Journal is, I believe, the best summary that I have ever read. It very concisely delineates the activities of a good control program. May I quote it as our slogan, "To diagnose the greatest possible percentage of unsuspected cases of tuberculosis, to place these people under immediate and adequate care, to render them and the community safe from further spread of their disease, to rehabilitate every patient into a productive member of society—these are our tasks."

COMMUNIQUE

May 30, 1944

To the Editor:

Today I received the "Spice of Life" and it is pretty good. In fact, I was not the only one who enjoyed it. I have also enjoyed your letters and the remarks in The Journal of the Arkansas Medical Society. Only last night I had the pleasure of seeing "Dr. Wassell" at the post theater.

I am winding up my second year here. We have been very busy since the day I arrived. It has been a great education and, from the international standpoint, I have learned lots and can appreciate the domineering mind of the Reich.

Shortly I shall be on my way overseas. At the present time I am just waiting orders out of Washington. I hope that I may have the pleasure of being in contact with the Arkansas Medical Society and your letters. Needless to say, I enjoy the jokes that are usually included with the letters.

Sincerely,

Lorenzo D. Massey, Major., M. C.
Camp Surgeon, Station Hospital
Prisoner of War Camp
Roswell, New Mexico

COMMUNIQUE

May 25, 1944

To the Editor:

Your letter came today. I enjoyed the contents very much and especially the feminine reaction when having a tooth pulled. All of our officers enjoyed it, too, especially the dentists.

I'd like to have Dr. Shuffield out here. I've had some of the most unusual fractures you can imagine.

We have nurses on our island now and people are calling on me that I never knew before to get that introduction. It's a personal opinion, but I am convinced a woman has no place in an army in shape, form or fashion. You have no idea how efficient and thorough male nurses can be until you have seen them tried as I have. Most of our male nurses have had six months' training in a good hospital and I can say they are tops under trying conditions.

We have everything we need out here in the way of food and supplies. Sweet milk is the only thing I miss now. Even orchids grow wild here. Send me another extraction extract.

Sincerely,

Ed Dunaway, Capt., M. C.

MEETING OF THE SPECIAL COMMITTEE ON MATERNAL AND CHILD WELFARE OF THE ARKANSAS MEDICAL SOCIETY

Little Rock, April 16, 1944

The committee met at the Marion Hotel at 4 p. m. The chairman, Dr. S. A. Thompson of Camden, and the following members were present: Dr. Robert Hood, Russellville; Dr. E. C. McMullen, Pine Bluff; Dr. J. G. Gladden, Harrison, and Dr. Don Smith, Hope. Dr. T. T. Ross, State Health Officer; Dr. J. T. Herron, Acting Director of Local Health Service, and Dr. Frances C. Rothert, Acting Director, Division of Maternal and Child Health, were present, representing the Arkansas State Department of Health.

The items below were agreed upon; for the Emergency Maternity and Infant Care Program:

1. **The clarification of the effective date of eligibility** by which it was made clear that if the husband was promoted out of the lower four pay grades before the receipt of the application in the State office, the woman would no longer be eligible, but if the application was approved before promotion the approval was not voided by such promotion.

2. **Clarification of length of stay available in hospital:** The hospital should agree to keep the patient for ten days, if space is available and the patient so desires. Stays longer than two weeks should have supplementary authorization which is always available in cases of medical need.

3. **Effective date of authorization:** It was suggested that the effective date of authorization should be the date during pregnancy when the wife first requested care under the EMIC program from the physician, provided that the application signed by the physician is received by the State Board of Health within six weeks after the date when the wife first requested care under the program. If the application is not received within six weeks after the wife first requested care under the program the "effective date of authorization" shall be a date not more than six weeks prior to the date when the application signed by the physician was received by the State Board of Health unless the application is accompanied by a letter of explanation from the physician or mother which (1) establishes an acceptable reason for the delay in application, (2) indicates the amount of care previously given and (3) shows that no payment has been made to the physician by or in behalf of the wife for

care during the period to be covered by the authorization. Application for delivery care received after the date of delivery would be approved for authorization **only** when supported by information indicating a medical emergency such as premature delivery or a situation beyond the control of the patient such as delay in mail, misunderstanding in procedures, misinformation, or other valid reason.

4. **Effective date of authorization—Infant Care:** Ten days instead of the present one week would be allowed for the receipt of application for infant care in the office. If delayed longer than ten days, an explanation similar to that described under Maternity Care must be made.

5. **In exceptional cases additional payment for attending physician's services for the mother beyond six weeks postpartum** may be authorized for continuing care for a serious acute complication resulting from pregnancy; such as, puerperal infection. It was explained that such cases had occasionally been authorized in the past.

6. **Medical care of other intercurrent and minor non-obstetric condition:** It will now be possible to make additional payment for attending physician's services **when especially authorized by the State or local Health Agency** during pregnancy and six weeks postpartum for the home or hospital treatment of intercurrent conditions not attributable to pregnancy, which do not require major surgery, at weekly rates of payment for medical care not to exceed \$12 for the first week of illness and if fewer than four home or hospital visits made during the week proportionate payment to be made for services rendered. For succeeding weeks of illness, a rate of payment not to exceed \$6 a week, and if fewer than three home or hospital visits are made during a week, proportionate payment to be made for services rendered. Care may be authorized for three weeks with provision for extension of authorization after review by the State Health Agency.

7. **Pregnancies terminating in spontaneous abortion:** The upper limit of fees for care of pregnancy terminating in spontaneous abortion not requiring an operation can now be only \$15 plus a proportionate payment for prenatal examinations made. As this is a requirement of

the Children's Bureau, it is necessary to accept it. It was pointed out that the simple spontaneous abortion is referred to in this.

8. Payment for medical care for infants: The limit on fees for the first week of illness will be raised from \$10 to \$12, and on succeeding weeks from \$5 to \$6.

9. Limit on amount for travel: It will be necessary to place a maximum of \$25 for a physician for travel in any one case. This is required by the Children's Bureau. It was pointed out that in only one or two cases had an amount larger than this been requested. Practically all request for payment for travel fall below this amount.

10. Authorization for cases of prolonged illness: At the special request of the physician authorization for a period of two months may be made on the first authorization for premature infants and other cases in which it is known that an illness will be prolonged. Extension for another month at a time may be made, if necessary. For ordinary cases, the initial authorization is only for three weeks before extension must be asked for.

11. Hospital minimum requirements: A few additions to the list of hospital minimum requirements which are in effect a clear statement of conditions already practically demanded were discussed. These include facilities for disinfection or sterilization of bed pans, adequate and suitable receptacles for soiled linens, adequate food and provision to exclude visitors from contact with infants.

12. Changes in the method of payment for hospitals as described in a new information circular from the Children's Bureau was briefly discussed with the committee. The changes suggested were favored by this committee, but are to be referred to the Hospital Advisory Committee before adoption.

13. Definition of major and minor surgery: It has been recommended by the Children's Bureau that State Agencies define major and minor surgery so that long, detailed lists of operations would not be necessary. The following definition of major surgery drawn up by the Cleveland Hospital Council and quoted in the twenty-sixth annual hospitalization survey, the American College of Surgeons, December 1943, has been called to the attention of State Agencies:

"1. Operations within or upon the contents of the following cavities

- a. The cranium
- b. The thorax
- c. The abdomen including the pelvis

2. Other conditions which because of their locality, the condition of the patient, a difficulty or the length of time required to operate, constitute a distinct hazard to life." Rates of payment up to a maximum of \$50 may be established for such operation. After some discussion it was recommended to adopt the definition just given. It was decided to establish an intermediate group with payment up to a maximum of \$25 for a certain group of surgical procedures that were not covered by the definition either of major or minor surgery. The following definition was recommended: "Other operations which because of their locality, the condition of the patient, their difficulty or the length of time required to operate, and the amount of after-care required justify a higher rate of payment than that established for minor surgery." For minor surgery, the rate of payment will not exceed \$10.

14. Appointment of consultants: The Children's Bureau requires that men used as consultants either meet the requirements of the various Specialty Boards or at least have had at least one year's postgraduate training in their specialty and one year's experience limited to the practice of the specialty. For areas where there are no consultants with these qualifications a State technical advisory committee appointed by the State Health Agency for this program should recommend a plan for providing consultation to patients living in such areas. It was pointed out that in many areas of the State, there are no physicians who have been certified in a specialty by their respective Specialty Board or meeting the requirements of such boards, nor are there physicians with special training in a specialty. However, there are men who by reason of long experience and eminent attainments are used by their colleagues as consultants in many cases. It will be necessary to select certain men for consultants in many parts of the State, and the State Department of Health wishes assistance in this. Questionnaires have been sent to all men who are graduates of Class-A or Class-B schools, and sixty-two of the questionnaires returned. Thirteen of those answering would qualify under group one (those certified by a Specialty Board); eighteen would apparently qualify under group two (those who have had special training in their specialty of at least one year, but who are not

certified by the Specialty Board); the rest would have to qualify under group three (those who are especially appointed for the locality on account of eminent attainment). It was recognized, also, that a number of men would qualify under group three and who are now being used as consultants had not submitted completed questionnaires.

The committee recommended that the question of the selection of these consultants be referred to the Technical Advisory Committee of the Division of Maternal and Child Health of the State Department of Health.

COMMUNIQUE

May 23, 1944

To the Editor:

Since receiving the "Random Thots" I have felt indebted to you for them. I note that Shippey sent you a copy of the "Yank." We all like it very much but the "Round-Up" seems to top them all. Shall send you one the first time I get an extra copy for immediately upon releasing them there is a mad scramble. You are lucky to get one copy. It is published right here and we think it contains some very good articles.

I recently received a letter from one of the colleagues who evidenced envy for my being in * * *. I would like to see an eminent psychiatrist for a consultation on this fellow. He must be bitching for a section eight. Would like to tell you all something about this country but am forbidden to upon threat of answering by first endorsement hereon. It might interest you to know that * * * is one of the garden spots of the * * * area as far as climate is concerned but the trip over is just a little tedious and high flying. Being a flight surgeon I am required to fly a certain amount, so that accounts for my trip although I was stationed there for a tour of duty.

Tell some of the boys to come over and I will take them on a tiger hunt from the back of an elephant. Be sure they are good shots or can hang on because the scent of a tiger seems to infuriate an elephant as the sight of one scares me. I suddenly went on a cross-country when one appeared and any time anyone tells you an elephant cannot run, you tell them that you know better. I just lost about enough fecal matter to butter a biscuit. Some fun, however.

Your jokes are the envy of the enlisted men in the dispensary.

Hope the election goes to suit all the boys. Believe I will let you all do the voting for me

and be sure and pick a good ticket.

My regards to all!

Yours,

J. O. Pierce, Capt., M. C.

COMMUNIQUE

May 8, 1944

To the Editor:

Been receiving "Random Thots" pretty regular here lately, which has been a very newsy letter and mentions many things and doctors whom I know.

A letter is the most looked-for item by all.

I've been in the army two years this June and haven't met up with any of my fellow doctors except when I returned to Little Rock on my last leave nearly nine months ago, after which I came overseas. * * *

By the way, I became captain January, 1943, and received my major's leaves October 2, 1943.

I received a letter some time ago from Mrs. Sanderlin which I enjoyed very much, and am glad she remembered me with such a nice letter.

My duties at present, as has been for nearly a year, are commanding officer of the "Clearing Company." It's really the hospital company of the division composed of field hospital units. I have 12 officers and sufficient technicians and enlisted personnel to do a lot of combat medicine or whatever you want to call it. I can assure you that there is no OB or GYN section, though.

Enclosed is a copy of "Stars and Stripes."

Well, suppose you are looking for the Big News, or who knows, maybe the war will be over by the time you receive this letter.

Sincerely,

Robert G. Young, Major, M. C.

COMMUNIQUE

May 24, 1944

To the Editor:

Thanks for your recent V-mail. I sure appreciate hearing from you.

No news from here. We get our magazines and newspapers months old. For example, the January 10, 1944, issue of "Life." The first article is of great interest to me and will be to you.

Best regards to all our friends and acquaintances. Please tell Crigler to have a long, tall one with you for me.

As always,

John J. Monfort, Capt., M. C.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

NO situation confronting the medical man demands more discriminating judgment than the management of tuberculosis when complicated by pregnancy. To terminate the pregnancy, to institute collapse therapy, or to adopt a policy of watchful waiting must be decided in the light of all factors, pathological, physiological and emotional. In the weighing of these factors, the experience of men who have made a special study of such cases is valuable.

PREGNANCY IN ADVANCED TUBERCULOSIS

The clinical onset of tuberculosis in many women is associated with pregnancy. Since collapse therapy has improved the chances of the tuberculous patient in general, re-evaluation of the effects of pregnancy upon the disease was undertaken. A selected group of 26 patients with tuberculosis, treated with various types of surgery was observed before or during pregnancy. The average period of clinical and roentgenologic observation was 9 years, during which 40 children were born of whom 36 were alive and well. Nine other pregnancies terminated prematurely. Tuberculosis was confined to one lung in 15 patients. In 11 it occurred in both lungs. Of the 26 cases with an effective collapse, only four showed an unsatisfactory course during pregnancy or following childbirth, and of

these, three later improved, the fourth had a spontaneous abortion. In three patients in whom collapse therapy was not satisfactory, there was a reactivation following childbirth.

In patients in whom the diseased areas of the lung are anatomically well collapsed, tuberculosis will not become active in pregnancy. Phrenic nerve interruption alone is inadequate. Physiologic, social and pathologic factors should be considered before determining the hazard of pregnancy but the safest interval for a tuberculous woman to have children is during the period of effective collapse therapy.

The Harmful Influence of Pregnancy on Advanced Tuberculosis as Modified by Collapse Therapy, J. W. Cutler, M.D., Amer. Jour. of Obstetrics and Gynecology, January 19, 1944.

THE TREATMENT OF THE TUBERCULOUS WOMAN DURING PREGNANCY

Pregnancy was advised at one period as a preventive or curative measure. Later the opposite course was advocated and therapeutic abortions were advised in all cases where the pregnancy was discovered before the fifth month.

Gradually the treatment of tuberculosis has become an attempt to control the tuberculous process itself. In this change of emphasis the necessity of aborting the pregnant tuberculous woman came to be questioned. Most of the adverse reports on the effect of pregnancy on tuberculosis came from obstetricians who compared the normal pregnant woman with the tuberculous pregnant woman. Pregnancy itself is a normal physiological process and normally not harmful. Tuberculosis is an infectious disease which annually kills thousands of women of child-bearing age even though pregnancy does not

exist. A study of tuberculous women, both pregnant and non-pregnant, was undertaken directing the main effort of therapy against the diseased process rather than against the normal physiological process to the end that the tuberculous pregnant woman could go to full term without interfering with her recovery from tuberculosis.

The woman with active tuberculosis should have bed rest plus such additional methods of treatment as pneumothorax and other collapse therapy which would be used if pregnancy were not present. Following labor more intensive treatment may be indicated to prevent a spread of the disease. Therapeutic abortion should be done only if a condition is found, other than the tuberculosis, to warrant it.

The arrested case of tuberculosis who becomes pregnant after leaving the sanatorium should re-

ceive more careful prenatal care than if tuberculosis did not exist. Many return to the sanatorium for care. Treatment varies with the condition. In general they receive modified bed rest for two or three months prior to delivery and strict bed rest for a month or six weeks following delivery. They are then allowed some activity and sent home when their babies are about three months old. The babies are isolated in the nursery until this time. Results in a series of cases extending over a 19-year period show that among 92 pregnant women who were studied 21 per cent died, while among 2,230 women of the same age group discharged for the first time from the sanatorium there were 837 deaths

or 39 per cent. The group is too small for definite conclusions but it does seem to indicate that when tuberculosis is properly treated pregnancy does not adversely affect it. The higher death rate in the non-pregnant group is unexplained.

Treatment of the pregnant woman with tuberculosis by the most modern means of combating the disease, together with equally modern prenatal care, apparently offers her as good a chance for recovery from her tuberculosis as though pregnancy did not exist.

The Treatment of the Tuberculous Woman During Pregnancy, E. S. Mariette, M.D., Leonard M. Larson, M.D., J. C. Litzenberg, M.D., Amer. Jour. of the Medical Sciences, June, 1942.

TUBERCULOSIS AND PREGNANCY

Type of Delivery

When delivery a woman with active pulmonary tuberculosis the severity of the illness and the extent of the lesion must receive consideration. The internist or phthisiologist must be responsible for the tuberculous condition during confinement just as he has been during pregnancy.

It seems good obstetrics to allow these women to come to term and deliver naturally. However, to induce labor ten to fourteen days early, when the condition of the patient permits, saves time when the load of pregnancy is greatest. The doctor should be liberal with analgesia during the early stages of labor and supportive treatment is necessary. The main points I wish to stress are: relieve pain, conserve energy, save blood and support the patient.

E. P. Allen, M.D.

Care

The most important thing during the puerperium and the months following is to treat the tuberculous disease. If the disease is under control, the outlook for the future is good. If in spite of therapy the disease progresses the prognosis is bad. The future destiny of the pregnant tuberculous female is dependent upon the character and the control of the tuberculous disease.

George G. Ornstein, M.D.

Indications for Abortion

Labor should not be induced in a case of pregnancy past the 28th week. In the rapidly progressive caseous type of tuberculosis, abortion should be avoided in the interest of the fetus. Where recovery from tuberculosis is highly probable, abortion should be done if the pregnancy has not advanced beyond the 12th (possibly the

16th) week. In other types of cases no rules can be formulated. Judgment must be based upon an adequate knowledge of the determining factors in each case. Conservation of pregnancy is usually safer than therapeutic abortion.

Willard R. Cooke, M.D.

Should She Bear Children?

The average woman with arrested tuberculosis is a desirable candidate for motherhood. She has been physically tested and psychologically disciplined by disease and will cooperate intelligently. There should be a period of about two years following arrest before it is safe to consider bearing a child. Consideration must be given to the economic situation of the prospective mother. Only the best of care and freedom from domestic responsibility will suffice to keep her well following delivery.

Lewis J. Moorman, M.D.

From a Symposium on Tuberculosis and Pregnancy, Transactions of Nat'l Tuber. Assn., 1941.

COMMUNIQUE

June 1, 1944

To the Editor:

Better late than never. Have intended writing thanking you and the Society for The Journal, letters, and now "The Spice of Life" has arrived.

Transferred to staff of Army and Navy General Hospital.

Thanks again.

Roy E. Schirmer, Capt., M. C.
Army and Navy Gen. Hosp.
Hot Springs National Park

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EDITORIAL COMMENT

DOCTORS AND POLITICS

It has become a trite saying that doctors are not politicians. With this saying there can be some general agreement. Doctors, however, are citizens and share equally with all other citizens in our government, whether this be good or bad. Certainly there has been a great lack of consideration and study of the processes of government, local, state or national, and of those selected to manage these processes by the mass of the population. Doctors, no less than other interested citizens, should give earnest attention to our governmental organization, and to those who are an active part of such organization. The physician is scientifically trained to dissect and analyze the fabric of the politician's promises, to bring the full play of studious logic into the evaluation of the fads and fallacies of campaign oratory, unswayed by the merits of friendship, hearsay or party organization. It does not seem too far-fetched to say that the coming party conventions and the November election may mark a turning point in the history of the world. Here in Arkansas it is most wise and expedient that physicians meet and discuss with the candidates for state offices, and from a full and frank viewpoint, determine who is best fitted

to represent the citizens of the state in government for the coming years. This is an obligation of every citizen. For physicians it becomes more than an obligation; it is the fulfillment of a trust and duty to ourselves, our colleagues, our citizens, our country.

SCHOLARSHIPS AVAILABLE

The Arkansas State Board of Health has available a limited number of scholarships for the Southern Pediatric Seminar at Saluda, North Carolina, July 17th to 29th. Travel, living expenses and tuition will be paid for a successful applicant. Applications should be sent to the Division of Maternal and Child Health, Arkansas State Board of Health, Little Rock.

RANDOM THOUGHTS OF THE SECRETARY

May 15th. Comes "The Eagle," a snappy paper from the Airforce at Eagle Pass, Texas, which reports the elevation of Flight Surgeon James M. Kolb to major.

May 16th. By air to Camden's desolate airfield, the cadets, the planes and all having departed, a preview of Victory, but would that more vacancies in war installations may soon occur. With Sam Thompson as ground pilot, a bit reckless it seems, on to Magnolia where the Fifth District meets with good attendance and program. Homeward, a flat tire is our lot, affording Sam the opportunity to collect part pay for our ride in labor. Thence, tired by unaccustomed exertion, to bed in a cool Ouachita Hotel room at a late hour.

May 17th. With a favorable tail wind, we take off from Camden at 6:30 a. m., viewing towns where colleagues have not as yet gone to work—Chidester, Gurdon, Caddo Gap, Mount Ida, Waldron, Huntington and Greenwood, to land at 8 a. m., ready for our own day's toil.

May 18th. In the late afternoon making a present-day unusual pilgrimage to Burns Gables where peace and quiet of the countryside brings full relaxation.

May 19th. Howard Armstrong sends a copy of the European edition of "Yank" and we have now viewed all "Yanks" and only await "Stars and Stripes," "Guinea Gold" and the "C.B.I. News," which Richardson, Maynard, Causey or someone should send to make it complete.

May 20th. Jim Branch sends "Stars and Stripes" and "Yank" from his theater and in the same mail comes a letter from C. Ray Williams, in the same area, which refers too frequently to the locale to permit publication in The Journal. Suffice it to say, Ray is, in his own words, "watching history made if not making any of it."

May 23rd. Louis Rudolph, the Chicago obstetrician, comes to town and Jones gives a steak dinner, gratifying social, professional and gastronomic aspects of life for all of us. To glorify the life of medical officers, we give a preview of Bill Stover's pin-up cards for our colleagues now in service, which is accorded long and enthusiastic reception.

May 24th. Today we achieve the ultimate in compliments when a patient tells us that we "are almost as nice as Dr. Chamberlain." By way of compensation Fount Richardson sends a copy of the "C.B.I. Roundup," contributing to our greater knowledge of global service papers.

May 25th. Practically the entire county society as guests at the Eberle Ranch despite a downpour and all are amazed that Goldstein could find the way. Food and drink being enjoyed, Rudolph speaks with conviction on prolonged labors and, in the questions and answers period, for some inexplicable reason, there enters discussion of the future considerations involved in episiotomies, closing the party in Falstaffian laughter.

May 29th. Today we mail Bill Stover's pin-up girls, "The Spice of Life," to all members in service and predict the same enthusiastic reception which Bill's Christmas card of a few years ago received from civilian physicians.

June 5th. Thanks to R. E. Smallwood who has secured the addresses of several lost members in service whom we have sought in vain these many months.

June 7th. With the family to Harrison this day, accompanied by Ruth Lesh, who does not like the curves on U. S. 62, Gateway to Eureka. The Ninth District turns out a 65 per cent attendance, a drop from their average, but still a good turnout in these days. The many pleasures of meeting with this group are in evidence and we regretfully leave the company of these good doctors.

June 6th. May this day which begins liberation bring us in America more to appreciate the sacrifices made that we may enjoy life, liberty and the pursuit of happiness.

June 9th. With the Chamberlains as guests of Veteran Shippey in Poteau where "burrageg, sahib" is the password and learned exposition on antiques mingles with less authoritative discussion on medicine and other subjects.

June 11th. Today journeying toward Chicago with the family and Wolferman. At Springfield thirteen soldiers, each with a missing eye, board the train for transfer to another hospital. Which brings on talk of those at home giving "until it hurts." We are making no sacrifice—merely lending lousy dollars. Let us at least buy more bonds than ever before in the coming Fifth Loan.

June 12th. The House of Delegates gets under way with many an old face and several new ones. From our day's survey of military medical men in attendance, we wonder if any of the lieutenants and captains got leave to attend—it's nothing below colonel so far. The uniform is so in evidence about Chicago that we do not feel that we have left Garrison Avenue and Fort Smith very far behind.

June 13th. The more serious matters are duly deliberated in executive session today with majority decisions determining all actions.

June 14th. Permitted to attend a section meeting and the exhibit hall today seeing only Delmas Kitchen and he away from his booth. To date crossing the paths of only Hoge, Wolferman and Wallis from the home state but tonight at the radiology dinner seeing for the first time in twenty-five years B. M. Johnson, a classmate, and it is hoped that Crawford and Dillman, both in attendance, get to see him.

June 15th. Closing out the meeting insofar as we are concerned and to the airport where a force of servicemen of near invasion strength elect to ride our flight and we return to town and to the good old Alton which takes in great comfort to St. Louis during the night.

June 16th. This extra day of absence spent in complete absence of effort, more of an unusual day than certain colleagues would suggest.

June 17th. Back to work, the day highlighted by the return of Jim Amis from Midway and Honolulu after two years out there.

PROCEEDINGS OF SOCIETIES

The Benton County Medical Society met in dinner session at Gravette June 8th for a program of case reports by members.

Geo. M. Love, Secretary.

The Ninth Councilor District Medical Society met at Harrison June 7th. After luncheon the following program was presented: "Obligations of the Medical Profession," Jos. F. Shuffield, Little Rock, and "Torsion of Ovarian Cysts in Children," Ruth Ellis Lesh, Fayetteville. Officers elected are: W. T. Bradley, Harrison, president; D. K. McCurry, Green Forest, vice president, and M. E. Rust, Harrison, secretary-treasurer.

The Sebastian County Medical Society was addressed June 12th by Maj. Paul L. White, "Neuropsychiatric Problems in Discharged Service Men," and Capt. Walter E. Vest, "Tropical Diseases Which May Be Encountered in Returned Soldiers," both speakers from Camp Chaffee.

D. W. Goldstein, Secretary.

The Craighead-Poinsett County Medical Society met at Jonesboro June 1st for the following program: "The Injection Treatment of Hemorrhoids," D. A. Dickerson, Marked Tree, and "Penicillin," H. A. Stroud, Jonesboro.

J. H. McCurry, Secretary.

The Fifth Councilor District Medical Society met in dinner session at Magnolia May 16th for the following program: "Certain Ocular Manifestations Resulting From Systemic Diseases," W. R. Buffington, New Orleans, and "Intravenous Anesthesia," Joe Nichols, Atlanta, Texas.

DURING FOOD SHORTAGES

It is well to bear in mind that **dried brewers yeast, weight for weight, is the richest food source of the Vitamin B Complex.** For example, as little as one level teaspoonful (2.5 Gm.) Mead's Brewers Yeast Powder supplies 45 per cent of the average adult daily thiamine allowance, 8 per cent of the average adult daily riboflavin allowance, 10 per cent of the average adult daily niacin allowance.

This is in addition to the other factors that occur naturally in yeast such as pyrodoxin, pantothenic acid, etc.

Send for tested wartime recipes, the flavors of which are not affected by the inclusion of Mead's Brewers Yeast Powder. Mead Johnson & Company, Evansville, Ind., U.S.A.

PERSONALS AND NEWS ITEMS

Lt. Lloyd F. Ritchey, Camden, is now stationed at Rhoads General Hospital, Utica, N. Y.

"The Promotion of Friendships Among Physicians" by L. H. McDaniel, Tyronza, which originally appeared in The Journal, was reprinted in the Congressional Record of May 15th.

Lt. Chas. C. Reed, Jr., Little Rock, is now assigned to Station Hospital, Camp Shanks, N. Y.

Capt. Robert L. Bryant, Arkadelphia, is now assigned to Station Hospital, Camp Polk, La.

S. C. Pierce has moved from Hartman to Lamar.

Lt. A. C. Watson, Jr., Little Rock, is now stationed at the Army Air Base, Lincoln, Neb.

Robert G. Young, Little Rock, now stationed overseas, has been promoted to major.

Lt. Chas. P. Harris, Jonesboro, is now stationed with 252nd AAA, S. L. Bn., Camp Stewart, Ga.

MARRIED—On May 9th, W. H. Daubs, Foreman, and Mrs. D. E. Nuchols, Texarkana.

W. L. Shippey, Fort Smith, has been retired from service with Medical Corps, Army of the United States.

Lt. Elbert H. Wilkes, Little Rock, is now stationed at Camp Bragg, N. C.

James M. Kolb, Clarksville, now stationed at Eagle Pass, Texas, has been promoted to major.

A. C. Shipp, Little Rock, has been elected representative director from Arkansas to the National Tuberculosis Association.

"Lesions of the Cervical Intervertebral Disk: Clinico-pathological Study of Twenty-two Cases" by E. Jefferson Browder, Brooklyn, and Robert A. Watson, Little Rock, was presented before the annual session of The Medical Society of the State of New York in New York City, May 10th.

Lt. John P. Eaton, Little Rock, is now stationed at Jefferson Barracks, Mo.

Lt. J. B. Wharton, Jr., El Dorado, who has been in service overseas, is now stationed at the Naval Hospital, San Diego.

Lindsley F. Billingsley, Monticello, addressed the Monticello Rotary Club May 18th on "Socialized Medicine."

Capt. Roy E. Schirmer, Fort Smith, is now on duty at Army and Navy General Hospital, Hot Springs National Park.

W. O. Arnold, State Sanatorium, has accepted appointment on the staff of the Scott and White Clinic, Temple, Texas.

L. L. Fatherree addressed the Little Rock Young Business Men's Association June 5th on "Facts You Should Know About Venereal Diseases."

Maj. Lewis M. Henry, Fort Smith, is now stationed at Army Air Field, Birmingham, Ala.

Lt. Ewing M. Nixon, Little Rock, is now hospitalized at Kennedy General Hospital, Memphis.

Capt. E. D. Rowland, Hot Springs National Park, is now stationed at Fairmont Army Air Base, Geneva, Neb.

Lt. Col. John W. Dorman, Dyess, is now stationed with the 427th Ambulance Med. Bn., Camp Carson, Colo.

Capt. Jones W. Lamb, Paragould, is now stationed overseas.

Lt. Col. Joseph O. Boydstone, Hot Springs National Park, is now stationed overseas.

Maj. Glenn G. Hairston, Prescott, is now stationed with the 31st Armored Regiment, Camp Young, Cal.

Capt. James W. Burnett, Texarkana, is now stationed with the 71st Infantry at Fort Lewis, Wash.

Lt. Thomas L. Adair, Searcy, is now stationed at Jefferson Barracks, Mo.

Maj. Vann Binns, Monticello, is now stationed overseas.

Lt. Art B. Martin, Fort Smith, is now stationed with the 2nd A F Repl. Wing, Army Air Field, Lincoln, Neb.

Capt. Jones W. Lamb, Paragould, is now stationed overseas.

Capt. M. E. Blanton, Jonesboro, is now assigned to Station Hospital, Fort Sill, Oklahoma.

Julius B. Askew, Little Rock, has been transferred to the San Francisco office of the United States Public Health Service.

Capt. M. W. Chastain, Bentonville, is now assigned to the 48th Field Hospital, Fort Jackson, North Carolina.

Lt. Leslie G. Holt, Little Rock, is now assigned to the 103rd General Hospital, Camp Ellis, Illinois.

Maj. W. W. Johnston, Little Rock, is now stationed overseas.

Maj. Monroe D. McClain, Little Rock, is now assigned to the 311th Eng. Battalion, Camp Livingston, Louisiana.

Lt. James F. Lewis, Fayetteville, is now hospitalized at Naval Hospital, Mare Island, California.

J. C. Moore and J. L. Ritchey, Jr., Helena, have been appointed captains, medical corps, Arkansas State Guard.

J. C. Ledbetter, Jonesboro, has been appointed lieutenant, medical corps, Arkansas State Guard.

W. F. Adams, Fort Smith, spent a recent vacation at Lake Hamilton.

W. R. Brooksher, Fort Smith, has been elected to the Board of Chancellors of the American College of Radiology.

Hoyt R. Allen, Little Rock, has been elected treasurer of the American Proctologic Society.

The following were registered at the Chicago session of the American Medical Association: Hoyt R. Allen, Little Rock; J. R. Barnett, Arkadelphia; W. R. Brooksher, Fort Smith; S. W.

Chambers, Mountain Home; G. C. Coffey, Hot Springs National Park; A. E. Cox, Helena; W. S. Crawford, Marianna; R. E. Crigler, Fort Smith; J. A. Dillman, Paragould; C. S. Early, Camden; P. C. Eschweiler, Little Rock; M. M. Even, Fort Smith; W. A. Fowler, Fayetteville; D. W. Goldstein, Fort Smith; W. G. Hodges, Malvern; A. F. Hoge, Fort Smith; N. T. Hollis, Little Rock; J. L. Jackson, Mountain Home; W. G. Klugh, Hot Springs National Park; N. J. Latimer, Corning; D. C. Lee, Hot Springs National Park; J. S. Levy, Little Rock; C. H. Lutterloh, Hot Springs National Park; E. C. McMullen, Pine Bluff; E. D. McKnight, Brinkley; A. R. Power, Hot Springs National Park; B. L. Robinson, Little Rock; J. F. Rushton, Magnolia; Howard Schwander, Little Rock; D. B. Stough, Hot Springs National Park; J. E. Stevenson, Fort Smith; E. B. Swindler, Stuttgart; Chas. Wallis, Little Rock; and S. J. Wolferman, Fort Smith.

STATE DEMOCRATIC COMMITTEE ACTION ON SOCIALIZED MEDICINE

Be It Resolved,

By the Democratic Central Committee of Arkansas in called session assembled at Little Rock, Arkansas, for the purpose of selecting delegates from this state to the Democratic National Convention of 1944 at Chicago, and for other purposes:

While conceding the necessity of temporarily surrendering some of the privileges of citizenship guaranteed by the Bill of Rights in our Constitution during the present emergency; this body, representative of democracy in Arkansas, is nevertheless concerned with the rapid growth of Bureaucracy and the steadily increasing invasion by the government in the field of private enterprise and professional freedom; and feeling that the present effort to socialize medicine is an unnecessary and unwarranted usurpation of control by the government of the private lives of its citizens, in no wise connected with the war effort;

Now therefore the delegates of the National Democratic Convention from the State of Arkansas are instructed to oppose the socialization of the private lives of the citizens of these United States.

Unanimously adopted this 17th day of May, 1944. Arkansas State Democratic Central Committee.

OBITUARY

ELBERT L. WATSON, aged 68, died at his home in Newport June 3rd. Born at Jacksonport in 1875, he attended Abbott School in Virginia, Columbia University and graduated in medicine from the Columbia University College of Physicians and Surgeons in 1900. During World War I he served as captain in the Medical Corps, resigning his position as mayor of Newport to enter service. He had served as Jackson County health director for several terms, was a member of the Episcopal church and had been president of the Jackson County Medical Society. In the Arkansas Medical Society he had served as delegate from his county society at several annual sessions and held appointment on various committees. Surviving relatives are his wife, two daughters and a son.

GEORGE W. FLETCHER, aged 74, died at his home in Montrose May 23rd. A graduate of the Memphis Hospital Medical College in 1896, he had practiced in Ashley County for 50 years. He was a past president of the Ashley County Medical Society. Surviving relatives are his wife, a son and a daughter.

WALTER GLADWIN ALLISON, aged 75, died at Hope May 24th. A graduate of Louisville and Hospital Medical College in 1908, he had practiced in Hope for many years and had served his county medical society in various offices. Surviving relatives are his wife and a daughter.

JAMES L. MERRELL, age 55 years, Walnut Ridge, died June 12th. A graduate of the Kansas City College of Medicine and Surgery in 1924, he located in Walnut Ridge in 1927. During World War I he served as an enlisted man in the Army Medical Corps. Active in the American Legion, he had served as commander of the Fourth District in 1938. Surviving relatives are his wife, a sister and two brothers.

WOMAN'S AUXILIARY PAGE

The Auxiliary to the Pulaski County Medical Society met May 17th for a luncheon in the home of Mrs. Paul Eschweiler, with Mrs. J. B. Crawford, Mrs. James Ryan, Mrs. Leo Aday and Mrs. C. D. Brooks, co-hostesses. Mrs. Randall Smith presided over the business meeting and heard yearly reports from the officers and committee chairmen. The following officers were installed by Mrs. C. W. Garrison: Mrs. Paul Autry, president; Mrs. R. T. Smith, first vice-president; Mrs. Vernon Newman, second vice-president; Mrs. Paul Fulmer, secretary; Mrs. Eschweiler, treasurer; Mrs. W. J. Schwarz, publicity chairman; Mrs. E. T. Webb, parliamentarian, and Mrs. Leo Aday, historian. Mrs. Charles Henry is president-elect for 1945.

BOOK REVIEWS

Synopsis of Diseases of the Heart and Arteries: By George R. Herrmann, M.S., M.D., Ph.D., F.A.C.P., Professor of Medicine, University of Texas. 3rd edition. PP. 516. 103 illustrations and 4 color plates. Price \$5.00. Saint Louis: C. V. Mosby Company, 1944.

The third edition of this popular work is a logical, sequential presentation of material in a most concise form, a volume of interest to student, practitioner and specialist alike.

Health Education on the Industrial Front: The 1942 Health Education Conference of the New York Academy of Medicine. PP. 63. Price \$1.25. New York: Columbia University Press, 1943.

This is a compilation of addresses delivered at the third annual Health Education Conference in which authorities discuss the problems of food and nutrition, maintenance of morale, control of accidents and detection of disease. This book will be of particular interest to physicians engaged in active industrial practice.

Female Endocrinology: By Jacob Hoffman, A.B., M.D., Demonstrator in Gynecology, Jefferson Medical College; Pathologist in Gynecology, Jefferson Hospital; formerly Research Fellow in Endocrinology and director of the Endocrine Clinic, Gynecological Department, Jefferson Hospital, Philadelphia. 788 pages with 180 illustrations, including some in colors. Philadelphia and London: W. B. Saunders Company, 1944. Price \$10.00.

The composition of the text is excellent and can be

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easily digested by the reader because of the simplicity of the phrasing.

The chapters devoted to Sterility, The Climacteric and the Menstrual Cycle will prove to be a great aid to the general practitioner as he is faced daily with such problems and this book offers many possibilities without being dogmatic.

The author offers treatment, diagnosis and the etiology in many of his chapters that are now fully accepted as proper and routine procedure in endocrine disturbances. He also cautions against the use of certain hormones just because a statement has been made that they are good for a certain symptom.

The section on the male is very short and adds but little to what has already been said and written on this subject.

WASTE PAPER IS NEEDED

From the day a soldier goes to war, he is dependent on paper. From his draft card to his honorable discharge, his records are kept on it.

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200 cartons containing one life preserver light, or
300 containers each containing one tube of poison gas ointment, or
100 cartons each containing 10 dozen fever vaccine.

Save all magazines, advertising material and other flat paper, keep it flat and if possible tie or put in a box. Waste paper is our NUMBER ONE CRITICALLY NEEDED RAW MATERIAL.

COMMUNIQUE

May 21, 1944

To the Editor:

Thanks for your letter of April 28th. Jabez Jackson was about one mile from my old unit

but I did not get his address in time to look him up. Maj. Frank Burton, Hot Springs, is only a few miles from my present location and I plan to visit him this week.

We are billeted in private homes. I am enjoying a real bed and many of the comforts of home.

Regards,

Max Hughes, Capt., M. C.

COMMUNIQUE

June 9, 1944

To the Editor:

Wish to thank you for The Journal that I have received regularly for the past few months. It has been interesting to read of the news from many of the M. O's. located in different parts of the world.

We are interested here in the latest developments on the coast of northern France and hope they turn out to be most successful. Therein depends our early return to the State of Arkansas.

Many good wishes until we return.

F. S. Dozier, Major, M. C.

COMMUNIQUE

April 2, 1944

To the Editor:

Your always welcome "Random Thots" just arrived. Though I am a relative newcomer to the Arkansas Medical Society, I at least know of the people that are mentioned and often I am acquainted with them. Thanks, too, for the membership card of the Society.

This letter will inclose a copy of "Stars and Stripes" and in another envelope I am sending a copy of "Yank." They are recent and perhaps will prove interesting to you. I don't see many "Yanks" myself but my day isn't complete unless I have read Ernie Pyle and Maudlin in the "Stars and Stripes." To my mind they are the best that the war has produced.

Yours,

Howard M. Armstrong, M. C.

COMMUNIQUE

April 17, 1944

To the Editor:

Thanks for the 1944 membership card and the letters with the Random Thots. I have had bronchitis and sinus trouble ever since I arrived in * * *. This liquid sunshine here does not agree with me. I have located a few of the boys from Arkansas. I had dinner with Frank Burton a few months ago.

Regards,

Max Hughes, Capt., M. C.

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No. 3

CONTINUOUS CAUDAL ANALGESIA IN OBSTETRICS *

I. FULTON JONES, M. D.

Fort Smith

For over one hundred years physicians have been searching for some drug or means to relieve the pains of childbirth. In the past few years the laity have been demanding that something be done to mitigate the ordeal of labor.

Childbirth in any language means labor. These pains are not only hard on the parturient physically, but neurologists insist that the nervous system is also affected. Many cases of neurosis and nervous instability have their beginning at this time. Numerous mothers speak of their labors as "nightmares" and do not want to experience such an ordeal again.

I believe that one of the reasons why we have so many one child families is this dread of the pangs of labor by so many women. We have all known this for many years but did not know what to do about it. We have read and studied the action of different drugs, but have never found one which we could use without fear of the dangers involved, either to the mother or to the child.

There has now appeared a method of relieving the pains in labor with safety to mother and child. This method has been used in surgery for many years with good success. It remained for Hington, Edwards and Southworth to apply it in obstetrics. We owe a great deal to these pioneers in this work. They have gone about its use as well as its promotion in the most cautious manner. They have stressed the contraindications even more than its indications. This has been done in order to keep down any untoward effects that might be achieved by its promiscuous use. We hear of its use in lay magazines as much as in our medical journals. We must face the issue, we must take up the banner and carry it forward, for it is possible today to relieve the pain of labor, and with safety to mother and child.

It has been used in thousands of cases. We have a report of over 10,000 cases with four deaths. In one of these, an osteopath used the method. In one, the patient had complete cardiac decompensation. The third patient was left by the doctor and nurse for over an hour with the continuous drip and that at four times the normal dose. The fourth case was from an infection.

Any analgesia that is used in obstetrics should fulfill three cardinal points; (1) it should be safe for the mother; (2) it should be safe for the child; and (3) it should not interfere with normal uterine contractions. I believe that continuous caudal analgesia comes nearer fulfilling these cardinal qualifications than any other we have today.

It is a technical procedure and should not be used outside of a hospital. No one should attempt its use until they have studied this procedure in detail. It requires the constant attendance of a qualified obstetrician or anethetist.

The dramatic relief of pain which these women experience recompenses you many times for the inconvenience of staying with them during their labor. There is no more appreciative patient than the woman who has been relieved of her labor pains. She feels so good that she often falls asleep and enjoys a much needed rest.

Every patient is not suitable for caudal analgesia. It should never be promised to any patient because certain obstetrical complications may arise that would necessitate its abandonment or non-use. Lull states that only about 65 per cent of women are suitable for caudal and that in 20 percent of these you cannot get a satisfactory analgesia because of anatomical abnormalities.

Its contraindications are:

1. Gross abnormalities of the sacrum.
2. Local infections around sacral hiatus.
3. Skin infections, i. e., boils anywhere on body.
4. Placenta praevia.
5. Sensitivity to the drug.
6. Hysteria.
7. Obesity.
8. Pilonidal cysts.

* Read before the Sixty-Ninth Annual Session, Arkansas Medical Society, Little Rock, April 17, 1944.

9. Disproportion of child to fetus, except in caesareans.

10. Floating head.

11. Inertia uteri.

It works beautifully in cardiac disease, upper respiratory infections and prematurity. Excellent results are also obtained in toxemia of pregnancy as well as in eclampsia.

Caudal analgesia should never be started until the patient is in actual labor. Many women often suffer painful uterine contractions who are not in labor. Caudal analgesia is given for the relief of pain, so until the patient actually suffers pain, it should not be started. This is usually at a time when the cervix is about 3 cm. dilated and pains are recurring every four to five minutes. The average duration of labor after caudal analgesia is started is about six hours. It has been carried for as long as thirty-two hours without any serious effect on mother or baby.

There are two main dangers in giving caudal analgesia. The first is that of giving a subarachnoid injection and the second is that of giving an intravenous injection. These dangers are actual, but can be prevented by giving careful attention to the needle and aspiration. Aspiration should be performed as soon as the needle is in place. If spinal fluid is obtained the needle must immediately be removed and the patient declared an unsuitable candidate for caudal due to a low lying dura. If blood is obtained by aspiration the needle is rotated 180 degrees, then withdrawn about one cm., the blood given time to clot, aspiration again tried, and if no blood is obtained, you may proceed.

Eight cc. of the anesthetic solution is used. Most men prefer 1½ percent solution of metycaine because of its low toxicity and its prolonged action. A ten minute waiting period is then observed. If there is no paralysis of the legs and especially the toes, then you may proceed with additional injection of 22 cc. of the anesthetic solution.

If the needle is in the caudal canal the patient will usually complain of pain in one or both hips. This is called sciatic sign. The pain can be relieved by a slower injection of the solution.

The patient will usually be free of pain in 5 to 15 minutes. She is then given additional dosage of 20 cc. every 30 to 60 minutes depending on height of anesthesia field. This height should be kept just below umbilicus. It should not be allowed above the xiphoid.

There is usually a slight fall in blood pressure of from 10 to 20 mm., rarely more, except in toxemia cases where it often falls dramatically down

to normal and remains so. Eclamptic patients often awaken with this blood pressure drop thus controlling the coma and convulsions.

It is good therapy to give a small dose of barbiturate before beginning caudal analgesia as this allays nervousness, aids in rest, and is an antidote for drug sensitivity.

Adequate fluids and nourishment should be given the patient. Her morale is to be reinforced by conversation and the radio. Changing her position from side to side relieves the monotony of lying in one position, also aids in relieving the one-sided analgesia.

The first stage of labor is shortened, but the second stage is prolonged. Most of the multiparas will be able to deliver spontaneously with you advising them when they have a contraction. Most of the primiparas will have to have outlet forcep for delivery. However, with the relaxation, you have an outlet forcep that is easy on the patient, the doctor and the baby.

It is important to be ready for the baby to breathe as soon as the head is over the perineum. We do not see any cases of asphyxia here so the mouth and air passages must be cleansed immediately. You must not give an oxytocic or manipulate the uterus due to its excellent tone and contraction. You will also note the small amount of blood loss. Often the loss from the episiotomy is much more than that from the uterus.

The bladder should be watched and emptied frequently. This can be done by pressure from above. If this fails, then it becomes necessary to catheterize. You see very few patients who have to be catheterized during the puerperium.

Caudal analgesia may be given in one of three ways, i. e., (1) malleable needle method is advocated by Hingson, and Edwards, (2) ureteral catheter method by Lundy, and (3) continuous drip method.

In closing I would like to give you a list of don'ts to remember:

1. Don't give it to any patient who does not want it.
2. Don't start injections too early in labor.
3. Don't think every patient is a suitable subject.
4. Don't forget to check patients pulse and blood pressure, as well as cervical dilatation, with position, presentation and heart rate of baby before starting injection.
5. Don't forget to check pulse and blood pressure at regular intervals.
6. Don't give full injection of solution until 10 minutes have elapsed after initial injection of

8 cc. and patient is still able to move her toes and feet.

7. Don't persist in inserting needle a second time if spinal fluid is obtained.

8. Don't attempt to use this method until you have studied it thoroughly and seen it given.

If you will take this new method of pain relief in childbirth and use it cautiously, noting its contraindications, I believe you will soon become very enthusiastic about its dramatic results. After all, the results we obtain from any technical procedure are proportional to the care and study we give it.

In addition to the relief of pain, there are several equally important beneficial factors associated with this method. They are: the excellent mental attitude that prevails, the absence of mental shock that often follows labor, the excellent condition of the baby, the nominal blood loss, the easy termination of the third stage of labor, and the return of the parturient to her room in the very best of physical and mental condition.

COMMUNIQUE

June 9, 1944

To the Editor:

Thanks again for "Random Thots" which I am always glad to get. Have come a long ways since writing you last. Have never walked so much in all my life and over the most difficult terrain. You know portable means you carry. We have made as many as 30 kilos in ten hours over mountainous country where only men and mules go. The monsoon rains and mud are terrific. You take one step and slide three. Have been up above the clouds. Coming down is more difficult for you usually slip down many times. The flies, fleas, mosquitoes, lice ("grey backs") are with us all the time. Uncle Sam sure was wise when he gave us all nets for without them we would be carried away. Have seen practically no white people except our own group for months. We eat rice t. i. d. and now claim twenty ways to fix it. Have been using jungle hammocks recently which is much better than one blanket on the ground except when the damn thing goes down with you at night when it is raining like the devil and you can't use any lights for good reasons.

Had a letter from Maj. Johnston recently but have never met him though I was near him once.

Our latrine here is also patronized by a nearby village and you never know who you will meet or who will come in and squat with you, both male and female. We have learned to do both functions in front of the opposite sex and now when

you want to go you really go ahead. The latrine is really a cosmopolitan place as you can readily see. Our * * * toilet paper is very tricky and if you are not on the job, you usually wind up by pushing your finger through. I am enclosing a piece for your own inspection but warn you the secret is to always use at least 4 thicknesses. We are good squatters now and would not feel at home on a QM box.

We do surgery for a * * * medical station, only emergency, not reconstructive, and have been busy lately. You probably have read about the recent events in * * * and perhaps know more than I do about it for news comes to us only by rumor. However, we hear things are coming along nicely.

Am inclosing the first page of the CBI Round-up, can't send the whole thing as it has about eight pages. Our mail comes to us once or twice a month. We get P rations each month, usually cigarettes and a couple of candy bars and gum. No beer or whiskey like other places get. However, we don't expect much in * * * but sure would like our part which no doubt someone is getting. It's bad enough to be here but not to get a few things takes the cake.

Will soon now have been overseas one year and wonder what things are like back in the States, and what the status in medicine will be when we return. If the government puts down our throats the socialized plan, I intend to buy me a farm and tell them to * * *. I'll never do surgery for Uncle Sam again after this war is over.

Let me hear from you again. It's always a pleasure. Keep up the excellent work.

Sincerely,

Hunter A. Causey, Capt., M. C.

COMMUNIQUE

June 19, 1944

To the Editor:

I just received notice of transfer effective July 1st, 1944, to the position of V-D Control Officer of East Baton Rouge Parish Health Unit. My new address will be 101 North Boulevard, Baton Rouge I, Louisiana.

Your stories are very good and I have enjoyed receiving them all, especially about Rosie McQueen, since I happened to have a field nurse here by that name and she swore that I changed the name for the occasion. I wish I had some good stories to return to you.

Sincerely yours,

William L. Bunch

SUGGESTED HEALTH PROGRAM FOR SCHOOLS FOR THE BLIND *

FRED W. HARRIS, M. D.

Little Rock

The cardinal principles of education are, Health, Citizenship, Worthy Home Membership, Vocational Guidance, Command of Fundamental Process, Worthy Use of Leisure Time, and Ethical Character.

It is seen, therefore, that Health heads the list in the cardinal principles of education. A child who is not healthy cannot be expected to do good school work. This not only applies to the child with defective vision but to any pupil. Since our great peace-loving country has been brought face to face with the horrors of war, it has been clearly demonstrated that health has been sadly neglected in our educational system. This applies not only to state and eleemosynary institutions but also to our general educational program. This has been concretely illustrated by the numbers of men who have been rejected for military service due to physical disabilities.

Too often the child with defective vision is spoken of with pity and, in some instances, made to feel that he carries a stigma due to lack of vision. From the psychological standpoint, it is important to have the child with defective vision feel that he is a normal child and that he may take his place in society.

I have selected the Health Program for the Arkansas School for the Blind as a skeleton outline from which modified programs may be initiated in any school regardless of size. It is with pardonable pride that we call your attention to our own health program.

1. When the pupil arrives at the school, after registration is completed, he is taken immediately to the doctor and nurse where he is inspected for infectious diseases, scabies, and pediculosis. Any infected child is immediately isolated to prevent spread of disease.

2. All new pupils are carefully examined by the physician, the eye specialist, and the dentist as soon as their adjustment program is finished. All former pupils who are known to have defects are also given a complete physical examination. A routine examination for all pupils is done by the school physician, the eye specialist, and the dentist as soon as possible.

3. Urinalyses and blood Wassermans are done

upon all new pupils and on all former pupils who have had kidney trouble or are known to have had a positive blood test. Any child who is found to have nephritis or diabetes mellitus is treated and special diets prescribed. All children with positive blood Wassermans are treated for syphilis.

4. All pupils are measured and weighed upon admission to school. Pupils found to be under- or over-weight are weighed each month. All pupils are weighed three times each school year. The underweight and undernourished children have special diets prescribed for them and they have a special diet table so that they may get the recommended diet.

5. The immunization program is complete. All new pupils are vaccinated for smallpox, and immunized against diphtheria and typhoid fever. Each child is reimmunized against typhoid fever every three years. Special attention is called to the cold vaccine program. For the past two years we have been pleased to find that the incidence of colds and the school days lost, due to colds, have been reduced at least 35 percent.

6. All new pupils are given the skin test for tuberculosis. If the child shows a positive test an X-ray of the chest is made.

7. There are three clinic periods each day and the child who does not feel well may report for clinic. These hours are scheduled before school, at the end of the noon lunch period, and immediately after school so that the pupil does not lose time out of class. This clinic hour held by the school nurse also serves to check any pupil referred to the clinic by the teacher. The home room teacher has been of great assistance in preventing the spread of colds and contagious diseases by having a short period of possibly five minutes at the beginning of school in the morning and again in the afternoon to check her pupils to see if there is evidence of colds, fever, headache, et cetera. This reduces the spread of communicable disease by sending the child immediately from the room to the infirmary. If the nurse thinks it is safe for the child to return to school she writes the teacher a note stating so. If he is sufficiently ill he is put to bed and seen by the physician.

8. Corrective work. The eye specialist has an opportunity to do a great service—sometimes by surgery to restore vision to the level where a child may continue his studies in the public schools. Many tonsillectomies are done, as are some plastic operations to improve the cosmetic appearance of the child. The dentist always has

* Presented at the Thirty-Sixth Biennial Convention, American Association of Instructors of the Blind, Little Rock, Arkansas, June 27, 1944.

a large volume of work to do and he does it very well.

9. Health Education. Programs each month are presented before the student body. This tends to make the children more health conscious. Light plays and pageants that have to do with health education and to inspire personal hygiene are presented. Once each year it is well to have a psychiatrist talk to the student body on mental hygiene.

To encourage the children to better health goals, medals are given at commencement time to two boys and two girls who have made the most progress in health. One boy and one girl over 12 years of age and one boy and one girl under 12 years of age are eligible. A dental medal is given to a boy and a girl each year to encourage dental hygiene.

10. Playground Supervision. It has been found that the majority of minor accidents occur on the playground. It is highly desirable that children have playground supervision after school hours. This will reduce the number of accidents and will make for better sportsmanship among the children.

A well-rounded health program cannot succeed in any school without the whole-hearted cooperation of the entire faculty. Specifically, in our program we have the cooperation of the home room teacher, the dietitian, and the physical education department.

The dietitian cooperates by planning special diets and seeing that the child eats. The physical education department does a grand job in aiding in giving corrective exercise to the children who have defective posture, muscle imbalance and in generally building up a strong, well-developed body. The nurse has a major role in the health program. Her outstanding qualifications should be, first, an interest in the child; and second, willingness to work beyond and above the usual call in the line of duty. Cheerfulness and kindness are wonderful attributes.

With the exception of playground supervision, the ten point program outlined for you is now maintained at the Arkansas School for the Blind. A program of this nature cannot be attained in a short time. It takes the whole-hearted cooperation of the superintendent, the nurse, the faculty, the dietitian, and the physical education department. We are very proud of our program and feel that it is one of the best to be found in the entire United States.

COMMUNIQUE

June 8, 1944

To the Editor:

Thanks a lot for the addresses and for the letter. I think that I can use the addresses very satisfactorily by having the security officer look them up for me. Sometimes that works and sometimes the Red Cross can help a little. I am going to try and find a few of the boys that are mentioned, but with things such as they are now, I find that I do not have a lot of time for much visiting. Locations change so rapidly that it is hard to keep up with the few that I have already located. Strange as it seems, I have not contacted an Arkansas medic in all of * * *. There seemed to be plenty of them in the States but now we are so scattered.

I have been able to get quite a bit of news from home and have kept up with a lot of events that are occurring. It seems that you folks know about as much about the war as we do. Here we see only one phase of it. It is mighty interesting but censorship prevents any information on the subject.

By the way, I would like to have the next issue of The Journal and it can be sent to this address. I have come to miss a lot of the medical literature that I used to have available, for now, about all the time we get is army instructions on how to treat men the army way. Sometimes I like a little change in diet.

I know of no important news except that there is still a war on—and you know what Sherman said about war.

Sincerely,

C. Ray Williams, Capt., M. C.

COMMUNIQUE

June 2, 1944

To the Editor:

Was so glad to have your letter of April 24th. It reached me right in the midst of moving day. We are now in * * * and very happy over it. Our stay in the old place was a series of long waits with nothing to do. Was glad to hear that Sisco had been in this area but he was moved out over a month ago.

We have a wonderful place over here—grand location, nice climate and much better food. The hospital is almost a story-book one with prefabricated buildings, running nurses, and cold showers. Incidentally, provisions for the girls are excellent considering that this is a forward location. We hope to do a decent bit of work here.

My regards to all,

Louis Hundley, Capt., M. C.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

WHEN an individual with congenital heart disease acquires tuberculosis it is a serious mishap. The medical adviser must then make the choice between conservative treatment of the tuberculosis or using some form of collapse therapy with the attendant risk of burdening the already embarrassed circulatory systems still further. A recent study of a number of cases suggests that prompt and active therapy directed at the tuberculosis offers the best chance of preserving the already short life span of these individuals.

PULMONARY TUBERCULOSIS ASSOCIATED WITH CONGENITAL HEART DISEASE

It is commonly accepted that individuals suffering from congenital heart disease are prone to develop and later to succumb to pulmonary tuberculosis. Of all patients with congenital heart anomalies it is those with pulmonary stenosis who seem most likely to develop tuberculosis. Whether it occurs more frequently in this group than among a comparable number with normal hearts cannot be stated positively without detailed statistical analyses. Case reports seem to show that tuberculosis is no greater menace in patients with pulmonary stenosis than is their cardiac defect.

It is true, however, that many persons born with this anomaly die before they have relatively much opportunity to develop tuberculosis, many of them being so incapacitated that they are protected from infectious contacts. If predisposition does actually exist it must arise primarily in the faulty oxygen and blood exchange characteristic of these cases.

This study concerns the frequency of congenital heart conditions in a tuberculosis institution, the course of the pulmonary disease and the efficacy and advisability of collapse therapy in the face of the cardiac handicap.

In the course of 1,545 necropsy examinations of tuberculosis individuals, seven cases of congenital heart disease were discovered, an incidence of 0.4 per cent. This incidence may be higher than in most other tuberculosis institutions due to the fact that one out of eight beds in this hospital is allotted to pediatrics. It is lower than that observed in institutions devoted entirely to the treatment of children.

The diagnosis made from the symptoms and physical examination of six additional patients

coincided unusually well with the defects found in the seven cases that came to autopsy. They exemplify the grouping of cardiac anomalies known as the **tetralogy of Fallot**. A picture of this condition is represented by this composite case report: The patient is a white youth in his lower teens. The history records cyanosis from birth or shortly thereafter and the diagnosis of congenital heart disease was made early. At that time the child was placed on restricted activity and followed in a hospital out-patient department. He has had no evidence of congestive failure and has led a fairly normal life until the onset of the pulmonary disease. Examinations show a young-appearing, under-developed child not, as a rule, dyspneic, but with cyanosis and clubbing of the fingers and toes. The heart is enlarged in all dimensions, with a loud, harsh, systolic murmur at the base, usually associated with a systolic thrill. The lung findings are dependent upon the pulmonary pathology. Laboratory tests indicate a well-marked polycythemia and there are tubercle bacilli demonstrable in the sputum. Roentgenography and fluoroscopic examination demonstrate enlargement of both ventricles frequently more marked in the right and a prominent pulmonary conus. The venous pressure is within normal limits and the blood pressure tends to be normal or slightly decreased. In the electrocardiogram are found right-axis deviation with tall P waves, these often being notched. The pulmonary disease has not influenced the findings typical of the combined heart lesions making up the cyanotic group.

The onset of pulmonary disease in these cases was similar to that of patients without congenital heart disease. Some or all of the usual symptoms

of tuberculosis were present in all cases. No difficulty was experienced in differentiating between the congenital heart disease and pulmonary tuberculosis since the congenital anomaly was diagnosed in all cases prior to the onset of the tuberculosis. The disease was moderately or far advanced on admission to the hospital in all but one case. The course of the disease and the lesions at autopsy were similar to those observed in patients without the cardiac hazard. The duration of life depended upon the extent of the disease on admission and the effectiveness of collapse therapy when that was used. The longest duration in the series of 13 cases was six years, the shortest courses were seven months. The average duration of life from the onset of the pulmonary infection to fatal termination was one to two years.

As the lesions and other factors of the pulmonary infection are the same whether or not the patient has congenital heart disease and as the cause of death depends upon the pulmonary rather than the cardiac status, it is the lung rather than the heart which should be the focal point of therapy. When bed rest fails to arrest the progression of the tuberculosis infection or cannot accomplish cavity closure it must be supplemented by collapse therapy in spite of the cardiac pathology. When this procedure is adopted late in the course of the disease the possibility of arresting the tuberculosis is slight. The life expectancy of these patients even without the pulmonary complication is short. Nevertheless therapeutic measures, even hazardous ones, seem justifiable if they will prevent the patient from succumbing even more prematurely to tuberculosis.

In the group of cases here reported pneumothorax was instituted in five cases. In one case only was an effective pneumothorax established. In no case did collapse therapy increase the cardiac symptoms or lead to congestive heart failure.

It is recommended that congenital heart disease should not be considered a contraindication to thoracoplasty and in order not to deprive these patients of the few years of life expectancy due them, immediate operation may be more advantageous than a preliminary, often disappointing, trial of pneumothorax.

The Development of Pulmonary Tuberculosis in Congenital Heart Disease, Oscar Auerbach, M. D. and Marguerite G. Stemmermann, M. D., *The American Journal of the Medical Sciences*, February, 1944.

COMMUNIQUE

June 16, 1944

To the Editor:

This letter is to thank you for your thoughtful-

ness in sending me letters and *The Journal* from home. I have intended to write many times but fail to get around to it.

I am stationed in * * *, sunny to some people. The people here have no problem in water supply as all they use it for is christening, I suppose. Also, I believe that the birth control clinics should be notified of this virgin territory. I was going to * * * but the Hdqrs. and Hdqrs. Detachments beat me there, and they feel that the town is just large enough for them. I hope that we take Berlin soon as this may allow me to visit * * * before I come home.

In Africa they charged \$12.50 for doing away with one medium-sized Arab. We are anxiously awaiting the price list here.

When we first arrived, I was surprised to learn how long all of the soldiers had been here, none under 25 months. However, I soon learned to ask first: "How long have you been over," and then sneer very knowingly. By this method, I have had them raise the ante to as high as five years, which I am inclined to disbelieve.

Jack M. Sheppard, Capt., M. C.

COMMUNIQUE

July 11, 1944.

To the Editor:

I have been asked about the program that we have here in Arkansas with reference to "Post-War Medical Education" and I am interested in that, too. I am coming to you for the lowdown on it. Please take the time as soon as you can on this as Capt. Lindig wants to send the information on to some secretary of this movement in Philadelphia.

Well, with all the high hopes that I have had, this joint has loosened up and the boss man says that a bone graft will have to come now, so early next week I will start pounding these hot rubber sheets again. That is the hottest job that I have ever attempted and I don't mind letting it be known that it is a bigger obstacle to me than taking another anesthetic.

Did you hear about the old man down in Georgia who was asked the difference between a Yankee and a damn Yankee? The old man thought for a moment, then said: "I don't know as I know—I ain't never seen a Yankee yet."

Sincerely,

Byron A. Bennett, Maj., M. C.
Army and Navy Gen. Hospital
Hot Springs National Park.

THE JOURNAL

OF THE

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EDITORIALS

THE 1944 SESSION OF THE AMERICAN MEDICAL ASSOCIATION

The 94th annual session of the American Medical Association was held in Chicago June 12th to 16th with a total registration of 7,187, of whom 41 were from Arkansas. This was considered a good attendance under present-day travel and housing conditions. The usual excellent scientific and commercial exhibits, always attractions, were exceptionally well-attended. The caliber of scientific presentations was high and gave emphasis to the newer methods and procedures in medicine, particularly as reflected by war experience.

The activities of the House of Delegates were manifold. George Dock, of Los Angeles, was awarded the Distinguished Service Medal. Officers elected are: Roger I. Lee, Boston, President-Elect; Vice-President, Stanley J. Seeger, Texarkana; and Trustees, Louis H. Bauer, Hempstead, New York, and E. L. Henderson, Louisville. Among the actions of the House of Delegates the following are summarized:

1. Disapproval of the present policy of Selec-

tive Service in preventing the enrollment of a sufficient number of qualified medical students.

2. Criticism of the present Federal plan for maternal and child health care as administered by the Children's Bureau with the suggestion that the Bureau be transferred to another agency, probably the United States Public Health Service.

3. Recommended the establishment of a single governmental agency under which all health functions could be correlated in the interest of efficiency, with a commission of five or seven members, including physicians, and with a secretary in the cabinet of the President.

4. Favored voluntary pre-payment hospital insurance and advocated action by state medical societies to set up insurance plans for the payment of medical bills.

5. Adopted a re-statement of the platform of American Medicine, printed elsewhere in this issue.

The Association will meet in New York in 1945; in San Francisco in 1946, and in Atlantic City in 1947.

Members are urged to read the full report of the sessions of the House of Delegates and the addresses of the officers of the Association which appeared in The Journal of the American Medical Association of June 17th and 24th, and July 1st.

EDITORIAL COMMENT

RECRUITMENT OF PHYSICIANS FOR ARMY, NAVY AND VETERANS ADMINISTRATION

Recruitment procedures under which the state chairmen for physicians have operated for some time will be changed as a result of the following developments in the needs of the Army, Navy and Veterans Administration:

1. **Relaxation of Age and Other Requirements of the U. S. Navy.**—The U. S. Navy Medical Corps has recently increased its age limit to 55 years. Physical requirements have also been relaxed, with the result that men who have expressed a preference for Army service and who do not meet Army standards for general service may be referred to the U. S. Navy for consideration for commissioning by the Navy.

2. **Requirements of the U. S. Army.**—The U. S. Army Medical Corps will continue to commission for general and limited service men up to the age of 45 who have been declared available by Procurement and Assignment Service. In exceptional cases the U. S. Army will continue

to waive age requirements for men for specific position vacancies.

3. **Requirements of the Veterans Administration.**—Since December 1943 the need of the Veterans Administration for qualified physicians has greatly increased. Therefore the following plans have been set up:

(a) Physicians under 45 years of age made available to the Army and who are not physically qualified for duty with Army installations but who meet Veterans Administration requirements will be given Army commissions for assignment to duty with the Veterans Administration.

(b) Physicians under 55 years of age made available to the Navy and who are not physically qualified for duty with Navy installations but who meet Veterans Administration requirements will be given Navy commissions for assignment to duty with the Veterans Administration.

(c) Physicians between the ages of 45 and 63 years who have been declared available for appointment by the Army will be offered commissions by the Army for assignment to duty with the Veterans Administration only, except that those between the ages of 45 and 55 years found physically qualified for general service will be submitted by the Army to the Navy for consideration for duty with the Navy.

(d) Since the Navy will not appoint any physician who has passed his sixtieth birthday for duty with Navy installations or the Veterans Administration, all available physicians between the ages of 60 and 63 should be made available to the Army only for duty with the Veterans Administration.

G. I. BILL OF RIGHTS

In this issue The Journal publishes an analysis of Public Law 346, popularly known as the "G. I. Bill of Rights." It is felt that members now in military service will be interested in certain of the provisions of this law, particularly those relating to education, including refresher courses, and the title relating to the guaranty of loans, including loans for supplies and equipment to be used in a gainful occupation. Members who wish more detailed information may request a copy of the law from one of Arkansas' representation in Congress, or the state secretary will procure one for them.

FOR SALE—Complete office equipment, General Electric X-ray, excellent condition. Write Mrs. J. L. Merrell, Walnut Ridge, Arkansas.

THE SERVICEMEN'S READJUSTMENT ACT OF 1944

Prepared by the Bureau of Legal Medicine and Legislation,
American Medical Association, Chicago

The G. I. Bill of Rights (S. 1767) was approved by the President June 22, 1944, as Public Law 346, Seventy-eighth Congress. It contains six titles.

TITLE I

This title deals generally with hospitalization, claims and procedures, aid by veterans' organizations and the review of discharges or dismissals from the armed forces.

It declares the Veterans' Administration to be an essential war agency, entitled to priorities second only to the War and Navy Departments, such priorities, so far as they relate to materials, being extended to any state institution to be built for the care or hospitalization of veterans.

It authorizes an appropriation of \$500,000,000 for the construction of additional hospital facilities for veterans and sanctions agreements between the Administrator of Veterans' Affairs and the Secretaries of War and Navy for the mutual use or exchange of use of hospital facilities.

It provides for the detail of commissioned, appointed or enlisted personnel from the armed forces to the Veterans' Administration for periods not extending beyond six months after the termination of the war. It contemplates procedures to assure veterans of an opportunity to file claims for benefits.

It makes available adequate training in the use of prosthetic appliances in a Service or a Veterans' Administration hospital, "or by out-patient treatment, including such service under contract."

It sets up machinery for the review of certain discharges or dismissals from service, other than discharges by reason of the sentence of a general court-martial.

TITLE II.

This title provides a program for the education of veterans following separation from service.

Eligibility for Benefits.—Persons who served in the active military or naval services on or after September 16, 1940, and prior to the end of the war, for the prescribed length of time, and who shall have been released or discharged under conditions other than dishonorable, will be entitled to the benefits of this title.

Veterans must have served 90 days or more or must have been released or discharged from active service by reason of an actual service-

incurred injury or disability. The 90 days of required service must be in addition to (a) any period in which the person was assigned for a course of educational training under the Army specialized training program or the Navy college training program which course was a continuation of his civilian course and was pursued to completion; or (b) any period served as a cadet or midshipman at one of the service academies.

An otherwise eligible veteran over 25 years of age must show that his education or training was impeded, delayed, interrupted or interfered with by reason of his entrance into service in order to qualify for the additional education or training made available under this title. A veteran 25 years or younger is not required to make any such showing. His education or training is presumed to have been impeded, delayed, interrupted or interfered with.

An otherwise eligible veteran will be entitled, too, to a "refresher or retraining course" if he so desires.

Onset and Termination of Courses.—A course must be initiated not less than two years after either the date of the veteran's discharge or the end of the war, whichever is later. No education or training will be afforded beyond seven years after the end of the war.

Length of Courses.—An eligible veteran will be entitled to education or training, or a refresher or retraining course for a period of one year, or the equivalent thereof in continuous part-time study, or for such lesser time as may be required for the course of instruction chosen by him.

On completion of the one-year course, other than a refresher or retraining course, the veteran will be entitled to an additional course not to exceed the time he was in service after September 16, 1940, and before the end of the war and exclusive of any period he was assigned for a course of education or training under the Army specialized training program or the Navy college training program, which course was a continuation of his civilian course and was pursued to completion, and exclusive of any period he was assigned as a cadet or midshipman at one of the service academies.

The total period of education or training may not exceed four years.

Educational Institutions.—The veteran may select any approved institution to attend which will agree to accept or retain him. For reasons satisfactory to the Administrator of Veterans' Affairs, the veteran may change a course of in-

struction. If the progress of the veteran is unsatisfactory, the Administrator may terminate the course.

A list of approved institutions will be established in the following manner:

(1) The Administrator of Veterans' Affairs will be required from time to time to secure from the appropriate agency of each state a list of educational and training institutions, including industrial establishments, which are qualified and equipped to furnish education or training, including apprenticeship and refresher or retraining courses;

(2) The Administrator will be authorized to add additional institutions to such lists which in his judgment are qualified to participate in the program; and

(3) The institutions designated by the several appropriate state agencies plus the institutions designated by the Administrator himself "shall be deemed qualified and approved to furnish education and training to such persons as shall enroll under this part."

Educational or Training Institutions Defined.—The term "educational or training institutions" is defined to include:

"All public or private elementary, secondary, and other schools furnishing education for adults, business schools and colleges, scientific and technical institutions, colleges, vocational schools, junior colleges, teachers colleges, normal schools, professional schools, universities, and other educational institutions, and shall also include business or other establishments providing apprentice or other training on the job, including those under the supervision of an approved college or university or any State department of education, or any State apprenticeship agency or State board of vocational education, or any State apprenticeship council or the Federal Apprentice Training Service established in accordance with Public, Numbered 308, Seventy-fifth Congress, or any agency in the executive branch of the Federal Government authorized under other laws to supervise such training."

Payment to Educational or Training Institutions.—The Administrator will pay to each institution for each veteran enrolled in a course of education or training (1) the customary cost of tuition and (2) such laboratory, library, health, infirmary and other similar fees as are customarily charged.

The Administrator may pay for books, supplies, equipment and other necessary expenses, exclusive of board, lodging, other living expenses and travel, as are generally required for the suc-

cessful pursuit and completion of courses by other students.

Payments by the Administrator may not exceed, with respect to any veteran, the sum of \$500 for "an ordinary school year."

Maintenance Allowances.—While enrolled in and pursuing a course, a veteran will be paid a subsistence allowance of \$50 a month if without dependents and \$75 a month if he has a dependent. Such a person attending a course on a part-time basis and a person receiving compensation for productive labor performed as a part of their apprentice or other training on the job at institutions, business, or other establishments, will be entitled to receive such lesser sums, if any, as subsistence or dependency allowances as may be determined by the Administrator.

Rehabilitation of Veterans Entitled to Educational Benefits.—Any veteran entitled to vocational rehabilitation under Public Law 16, Seventy-eighth Congress, who is also entitled to educational training under the Servicemen's Readjustment Act of 1944, may elect which benefit he desires.

Federal Control Over Educational Institutions.—This title provides that:

"No department, agency, or officer of the United States, in carrying out the provisions of this part, shall exercise any supervision or control, whatsoever, over any State educational agency, or State apprenticeship agency, or any educational or training institution."

Excepted from the foregoing proscription are federal educational and training institutions over which federal jurisdiction is authorized by existing law.

Utilization of Existing State and Federal Facilities and Services.—The Administrator of Veterans' Affairs will be authorized to administer Title II and must, so far as he finds it practicable, utilize existing facilities and services of federal and state departments and agencies on the basis of mutual agreements with them. He may promulgate rules and regulations necessary to carry out the purposes of the title.

Vocational Guidance for Beneficiaries.—The Administrator may arrange for the educational and vocational guidance of beneficiaries undergoing courses under this title. He may make available information as to the need for general education and for trained personnel in the various crafts, trades, and professions, utilizing information, to the extent practicable, collected by other federal agencies.

Medical and Hospital Care for Beneficiaries.

—The appropriations made available to the Veterans' Administration for the medical treatment and hospitalization of veterans generally are made available for persons undergoing courses under this title.

Books, Supplies and Equipment.—Any books, supplies or equipment furnished a veteran will be considered as having been released to him. If because of fault on his part a veteran fails to complete his course he may be required to return any books, supplies or equipment not actually expended or to pay the reasonable value thereof.

TITLE III

This title relates to loans for the purchase or construction of homes, farms, and business property. It sets up machinery whereby the Veterans' Administration will guarantee loans made to veterans, provided the loans are to be expended for specified purposes. Those purposes are:

(1) The purchase, construction, alteration, repair or improvement of property to be occupied by the veteran as his home, or the payment of delinquent indebtedness, taxes, or special assessments on residential property owned by the veteran and used by him as a home;

(2) The purchase of land, buildings, livestock, equipment, machinery, or implements, or the repair, alteration or improvement of any buildings or equipment, to be used in farming operations conducted by the veteran; and

(3) The purchase of any business, land, buildings, supplies, equipment, machinery, or tools to be used by the applicant in a gainful occupation, other than farming.

The aggregate amount guaranteed by the Veterans' Administration may not exceed \$2,000 in a particular case nor 50 per cent of the loan negotiated for the purposes indicated. Provision is made for the guaranteeing of a second loan under specified conditions.

Application for the guaranty of a loan must be made within two years of separation from service or within two years of the termination of the war, whichever is later, but may not be filed later than five years after the war.

Interest for the first year on the guaranteed part of the loan will be paid by the Veterans' Administration and thereafter the interest on the guaranteed part of the loan may not exceed 4 per cent. The guaranteed part of the loan is to be repayable in twenty years.

PLATFORM OF THE AMERICAN MEDICAL ASSOCIATION

As Amended and Adopted by the A.M.A. at Its Chicago Convention, June 12-16, 1944

I. Availability of medical care of a high quality to every person in the United States.

In carrying out this widespread distribution of medical care and in any evolution necessary in the methods of administering medical care the basic principles necessary to the maintenance of scientific standards and the quality of the service rendered must be maintained.

It is not in the public interest that the removal of economic barriers to medical service should be utilized as a subterfuge to overturn the whole order of medical practice or the democratic plan of government. Removal of economic barriers should be an object in itself.

It is in the public interest that the standards of medical education be constantly raised, that medical research be constantly increased and that graduate and post-graduate medical education be energetically developed. Curative medicine, public health medicine, research medicine, and medical education all are indispensable factors in promoting the health, comfort and happiness of the nation.

In carrying out this objective, the A.M.A. advocates:

(a) In the extension of medical services to all people, the utmost utilization of qualified medical and hospital facilities already established.

There is no evidence that the American people wish different doctors or a different system of medical care. There is evidence that they wish that care more widely distributed and they wish some method of easing its economic burden, especially by prepayment plans. That the people desire a personalization of service is evidenced by the fact that in the present time of full employment the turnover in charity hospitals is at a new low and the semi-private and private beds in the private and voluntary hospitals are overcrowded, whereas in times of slack employment, the reverse is true.

The extension of hospital facilities should be carried out only after a careful survey which indicates that present hospital facilities are being used to the utmost or that there is a definite lack of hospital beds for a particular community.

Again, it has been argued that the demands for medical care in some sections of the country might require the importation of considerable numbers of physicians or the transportation of

numbers of physicians in the areas in which they now are to other areas. In this connection it would seem to be obvious that a change in the economic status of the communities concerned would result promptly in the presence of physicians who might be seeking locations. The utilization of existing qualified facilities would be far more economical than any attempt to develop new facilities. There are many emergency situations which may arise in time of war. In most instances these emergencies will not continue after the war. Where they do other arrangements must be made to meet them.

(b) The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability, including the development and extension of voluntary hospital insurance and voluntary medical insurance.

In the United States today our sickness and death rates are lower than those of any other country in the world. This fact is generally recognized. The great medical profession recognizes the importance of doing everything possible to prevent every unnecessary death. At the same time it has not been established by any available evidence that a change in the system of medical practice which would substitute salaried government doctors for the private practitioner subject to the control of public officials would in any way lower sickness and death rates. Compulsory sickness insurance in no instance has given as good a health record as the American system.

The medical profession has approved prepayment plans to cover costs of hospitalization and also prepayment plans on a cash indemnity basis for meeting the costs of medical care. It continues, however, to feel that the development of the private practice of medicine which has taken place in this country has led to higher standards of medical practice and of medical service than are found elsewhere and that the maintenance of the quality of the service is fundamental in any health program.

The American Medical Association has approved prepayment hospital insurance subject to the principles adopted by the House of Delegates. The number of people covered by it is constantly increasing. Its availability within their territory should be extended to all who desire it.

Medical expense insurance has developed slowly but much valuable experience has been accumulated. All constituent State Associations

have been urged to develop voluntary plans so that the entire country may be covered by such plans. The A.M.A. will assist in the development, correlation and integration of such plans. State Welfare Departments should consider the use of the insurance principle in caring for the indigent and medically indigent, rather than the present system. Industrial medical care plans on the voluntary principle must be investigated and developed under the guidance of constituent associations and component societies.

(c) Expansion of Public Health and Medical Services consistent with the American System of Democracy.

Careful study of the history of the development of medical care in various nations of the world leads to the inevitable conclusion that the introduction of methods such as compulsory sickness insurance, state medicine and similar technics results in a trend toward communism or totalitarianism and away from democracy as the established form of government. The intensification of dependence of the individual on the state for the provision of the necessities of life tends to make the individual more and more the creature of the state rather than to make the state the servant of the citizen. Great leaders of American thought have repeatedly emphasized the fact that liberty is too great a price for security.

(d) The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health and the care of the sick on proof of such need.

The physicians of the United States have given freely of their time and of their funds for the care of the sick. Their contributions to free medical service amount to at least \$1,000,000 a day. The physicians of this country have urged that every person needing medical care be provided with such care. They have urged also the allotment of funds for campaigns against maternal mortality, against venereal disease and for the investigation and control of cancer. The medical profession does not oppose appropriations by Congress of funds for medical purposes. It feels, however, that in many instances, states have sought aid and appropriation for such functions without any actual need on the part of the state, in order to secure such federal funds as might be available. It has also been impossible, under present technics, to meet actual needs which might exist in certain states with low per capita incomes, with needs far beyond those of

wealthier states, in which vast sums are spent.

It is proposed here simply that Congress make available such funds as can be provided for health purposes; that these funds be administered jointly by the county, state, and federal health agencies, mentioned in Section H of this platform, and that the funds be allotted to proof of actual need to the federal health agency, when that need is for the prevention of disease, for the promotion of health or for the care of the sick.

(e) The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.

Obviously if federal funds are made available to the individual states for the purpose mentioned in Section D of this platform, there might well be a lessened tendency in many communities to devote the community's funds for the purpose and, in effect, to demand that the federal government take over the problem of the care of the sick. Hence, it is suggested that communities do their utmost to meet such needs with funds locally available before bringing their need to the federal health agency, and that the health agency determine whether or not the community has done its utmost to meet such need before allotting federal funds for the purpose.

(f) The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.

The medical profession wishes to extend preventive medical services to all people within the funds available for such a purpose. Obviously, this will require not only a federal health agency which may make suggestions and initiate plans but also a mechanism in each community for the actual expansion of preventive medical service and for the proper expenditure of funds developed both locally and federally. In the development of new legislation, such mechanism may be suitably outlined.

So far as preventive medicine and general measures of public health are concerned, there is great need for the increase of county or district departments of health. There are still too many areas without such coverage. Every area in the United States should have a health service with adequate personnel and facilities to render the service necessary to each community. It should be integrated with and co-ordinated by the State Health Department. Federal funds may be used to help establish these departments where local funds are inadequate but the man-

agement should be under state and local authority.

(g) The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.

The medical profession does not yield to any other group in this country in its desire to extend medical care to all those unable to provide themselves with medical service. The American Medical Association has already recognized the existence of a group of persons able to provide themselves with the necessities of life commonly recognized as standard in their own communities but not capable of meeting a medical emergency. Hence, it is the platform of the American Medical Association that medical care be provided for the indigent and the medically indigent in every community but that local funds be first utilized and that local agencies determine the nature of the need and control the expenditure of such funds as may be developed either in the community or by federal government, as they are the most capable of determining the needs. Emergency and migratory labor may be a temporary federal responsibility. The use of the voluntary insurance principle should be considered by all agencies distributing medical care.

(h) The establishment of an agency of federal government under which shall be co-ordinated and administered all medical and health functions of the federal government exclusive of those of the Army and Navy.

Today the medical and health functions of the United States are divided among a multiplicity of departments, bureaus and federal agencies. Thus, the United States Public Health Service and the Food and Drug Administration are in the Federal Security Agency; the Children's Bureau in the Department of Labor; the Veterans' Administration and many other medical functions are separate bureaus of the government.

Since 1875, the American Medical Association has urged the establishment of a single agency in the federal government under which all such functions could be correlated in the interest of efficiency, the avoidance of duplication and a saving of vast sums of money. Such a federal health agency, with a secretary in the cabinet, or a commission of five or seven members, including competent physicians, would be able to administer the medical and health affairs of the government with far more efficiency than is now done.

REMARKS OF DR. R. B. ROBINS, CANDIDATE FOR DEMOCRATIC NATIONAL COMMITTEEMAN FROM ARKANSAS, BEFORE THE MEETING OF THE ARKANSAS PRESS ASSOCIATION AT HOT SPRINGS, JUNE 24, 1944.

Mr. Chairman and members of the Arkansas Press Association:

I thank you for the invitation to be here today.

I appreciate the fact that the Democrats of Arkansas are permitting me to become their next National Committeeman without opposition.

It is probably in order today to express my attitude, and what I believe to be the attitude of most Democrats of Arkansas, toward some prominent national party issues. Because of limited time I have written my remarks and will briefly discuss five outstanding issues.

Issue No. 1

We have grown a little tired of receiving so much Yankee Democratic advice regarding the Negro problem. That is a problem which we believe we have handled very satisfactorily in the past and we consider it a very inappropriate time now, when we have plenty of other troubles on our hands, to interject this racial issue. Our observation is that the Republican Party has always been the Negroes' Party of choice and I think it should remain that way.

Issue No. 2

We hope the poll-tax issue will not arise in our national platform. This is a States' rights matter.

Issue No. 3

We would like to see a return to the two-thirds rule in the convention. We Southerners lost our prestige in the Democratic Convention when the two-thirds rule was abolished.

Issue No. 4

We are interested in a Southern Vice President who is fundamentally a Democrat. The hazards connected with the Presidency during the next four years will be very great. It is highly important that a capable Vice President be selected. My personal choice is our neighbor from Texas, The Honorable Sam Rayburn, Speaker of the House of Representatives.

Issue No. 5

Finally, I feel that we all realize that it was necessary in order to prosecute the war that a number of bureaus had to be created. I am sure that we are all very conscious of the nuisance and danger of continuing a bureaucratic government after the war. We are all hopeful that we can return to a "free enterprise economy" after the

war and dispense with so much governmental regulation.

On the other hand, there are those in our very Party who would socialize and regiment our people to the gills. We are all in favor, I am sure, of **reasonable** social security. However, there are those in our very Party who would extend social security to the totalitarian point. It was well said and it is well for us to remember the remark of Eric Johnston: "You can have security in a jail, but you can't have freedom."

As you all know, there has been introduced in Congress a bill known as the Wagner-Murray-Dingell Bill, now dormant in committee only to rise again, which provides for a totalitarian scheme of security for the individual from the womb to the tomb. Under this bill the sum of three billion dollars is provided for medical care for the people of this country.

We speak of billions these days without any conception of what the figure means. I was doing a little simple arithmetic the other night which amazed me. Figuring 60 seconds to the minute, 60 minutes to the hour, 24 hours to the day, 365 days to the year and 1944 years, I determined that it had been only 61 billion seconds—not minutes—since Christ was born. Our national debt is over twice that figure in dollars and our national debt limit is over three times that figure in dollars.

I am staunchly opposed to a compulsory, political health insurance program for the American people. You can't tell me that the American people cannot afford medical care under a free enterprise system when they spend twice as much on tobacco and liquor than they do on medical care.

A man who purchases one package of cigarettes daily spends more than \$72.00 a year and that would purchase for him a very good health and accident policy.

My time is up and I will conclude by saying that I am fundamentally a Democrat and intend to support its nominees. I am suspicious of a proposed Republican leader with a little black mustache. It is indelibly impressed in my mind how much trouble and grief a man with a little black mustache over in Europe has caused the world.

RANDOM THOUGHTS OF THE SECRETARY

June 18th. "His name ain't on no tablets.

In no park his statue stands
All his life he grubbed for wages—
You could tell it by his hands.
The things he left behind him
Wouldn't load a sardine can,

But I'd like to get to thank him

For just bein' my Old Man."

June 25th. It looks like Task Force 58 is going to give the yellow boys 57 varieties of hell.

June 29th. Tonight in long distance conference with Democratic National Committeeman nominee Robins over plans and procedures for his debut party at Chicago July 19th, being in agreement over most of the details and unanimously agreed that this will be the something that the Democratic party will long remember.

June 30th. In the grand manner Hoge entertains at steak dinner for his colleagues and we carry away Pride's remark "I do not mind being in the army and not keeping up with medicine but I do miss Brooksher's speeches," somewhat of a left-handed compliment.

July 4th. Shall this Independence Day of ours have decreasing significance or shall each and every one of us become more vigilant, less indifferent and seek to maintain the rights of the individual, of freedom, and of civil liberties?

July 6th. There is a definite shortage of physicians at the Washington-Benton County Medical Societies picnic today but no shortage of picnic provender, good fellowship and worth-while presentations. President Shuffield arriving after adjournment manages a fresh-caught trout for lunch and later drives us to Prairie Grove to call on Mock and Baggett, both being away on duties, but Baggett senior interests Shuffield in fox hounds and a trade is made. Returning, Joe further enshrines himself with the young hopeful by letting him pilot the fluid drive Oldsmobile back to Fayetteville and only war-time restrictions deliver us from a clamor to "buy one of these, dad."

July 10th. George Stocker shortly out of the jungle visits bringing tales of the Marines but mostly impressed with having paid money to see movies in San Francisco of the Cape Gloucester show which was one of his jobs.

July 12th. Today Goldstein and Wolferman present matters of moment from the Chicago session of the American Medical Association to the Rotary Club and we attend as interested audience and share in the heckling.

July 17th. For the first time, the Navy lets us down by returning a letter addressed to Jim Lewis, and for the information of BuNav, Lt. Lewis is at Naval Hospital, Mare Island, California.

July 18th. Comes the report from McKenzie of a "believe it or not" incident of this war: Hope and Hempstead county's full medical representation in military service, Lt. Col. James W. Branch, Maj. J. G. Martindale and Capt. Jim McKenzie, met July 2nd on foreign soil and held an unofficial county medical society meeting, the first yet to be chronicled.

July 19th. In compensation for our inability to attend Bob Robin's big party in Chicago tonight, we discuss matters with a gubernatorial candidate, wishing very much that we could be with the "Big Show" as Committeeman Robins is surely putting it on.

COMMUNIQUE

June 12, 1944

To the Editor:

The Journal reaches me regularly but I want to tell you how much I have enjoyed the "Random Thots" and inclosed humor. Increasing distance from home makes the news of local affairs even more entertaining.

Capt. B. B. Wells, now a lab coordinator, and

Maj. A. F. DeGroat, in charge of a general hospital laboratory, and Alvin Longstreth, have all paid visits to me. They were in good health and spirits doing work they like. Alvin complained that no one in his outfit ever got sick or hurt. However, he had acquired some fresh eggs which he generously shared with me.

With all good wishes,

Carroll F. Shukers, Major, M. C.

PROCEEDINGS OF SOCIETIES

The Craighead-Poinsett County Medical Society met at Jonesboro July 6th for the following program: "On the Other Side of the Fence," O. T. Cohen, and the motion picture, "Continuous Caudal Analgesia in Obstetrics."

J. H. McCurry, Secretary.

The annual picnic session of the Washington-Benton County Medical Societies was held at the Brumfield Fish Hatchery, Fayetteville, July 6th. The following scientific program was presented: "War Effects on Civilian Morbidity," F. T. H'Doubler, Springfield, Missouri; "Cardiac Emergencies," Chas. T. Chamberlain, Fort Smith, and "Carcinoma of the Colon," A. D. Vail, Springfield, Missouri.

The Lawrence County Medical Society was addressed at its recent meeting in Mammoth Spring by E. C. Bohrer, West Plains, Missouri, and H. A. Stroud, Jonesboro.

Chas. D. Tibbels, Secretary.

COMMUNIQUE

June 5, 1944

To the Editor:

Many thanks for the nice letter, also for several issues of The Journal. It's good to hear from the old home state and to read The Journal again.

I'm glad you visited Columbia County again. Even though the inhabitants retire by eleven P. M., it is still a fair county and town. John is certainly busy. Can tell by the size of my check from the clinic each month. The boys there really put in a day's work and are doing a bang up job, too.

All news is good news over here. When, and if, the second front opens, we, over on this side of the pond, know it will be a success, for each and every one of us is determined it can be nothing but a hard-earned victory by a damn good team.

Let me hear from you again.

Fraternally,

H. K. Carrington, Capt., M. C.

PERSONALS AND NEWS ITEMS

Lt. Comdr. George F. Stocker, Fort Smith, who has been in the South Pacific for 23 months, has been assigned to Naval Hospital, Memphis.

"Medicolegal Aspects of Physical Medicine" by Capt. H. H. Buckelew, Little Rock, appeared in the June issue of Archives of Physical Therapy.

Lt. Art B. Martin, Fort Smith, is now assigned to Station Hospital, Alexandria Army Air Base, Alexandria, Louisiana.

I. H. Jewell has been elected surgeon of the Paris post, American Legion.

Maj. Stanley M. Gates, Monticello, has been transferred from Camp Chaffee to Veterans Administration Facility, Alexandria, Louisiana.

H. Fay H. Jones, G. W. Reagan, Little Rock, and H. King Wade, Hot Springs National Park, attended the recent session of the American Urological Society in Saint Louis.

Maj. L. D. Massey, Osceola, is now stationed at Fort Lewis, Washington.

Lt. Leslie G. Holt, Little Rock, is now stationed overseas.

E. Driver Rowland, Hot Springs National Park, now stationed at Fairmont Air Base, Geneva, Nebraska, has been promoted to major.

Capt. Frank M. Adams, Hot Springs National Park, is now assigned to Hq. 8th Med. Tng. Regiment, Camp Grant, Illinois.

B. V. Raley, Little Rock, has been promoted to lieutenant-commander.

The following were elected affiliate fellows of the American Medical Association at its 1944 annual session: Chas. E. Oates, North Little Rock; R. Q. Patterson, Little Rock; A. C. Shipp, Little Rock, and J. G. Watkins, Little Rock.

Maj. J. K. Donaldson, Little Rock, is now stationed overseas.

J. W. Butts has been elected surgeon of the Helena post of the American Legion.

Maj. Hollace D. Fowler, Little Rock, is now

assigned to the 86th Portable Surgical Hospital, Camp Howze, Texas.

Comdr. James W. Amis, Fort Smith, has returned from two years' duty in the Central Pacific and has been assigned to Camp Wallace, Texas.

Byron J. Binns, Monticello, now stationed overseas, has been promoted to major.

Lt. William L. Bunch, Jr., U. S. P. H. S., has been transferred to Baton Rouge, Louisiana, as V-D Control Officer for East Baton Rouge Parish Health Unit.

J. B. Jameson, Camden, spent a recent vacation at Lake Hamilton.

J. D. Riley, State Sanatorium, has been elected a Governor of the American College of Chest Physicians.

Floyd S. Dozier, Wilson, now stationed overseas, has been promoted to major.

J. L. Kellum, Fort Smith, has moved to Bogalusa, Louisiana.

C. C. Reed, Jr., Little Rock, now stationed at Camp Shanks, New York, has been promoted to captain.

Capt. H. H. Holt, Little Rock, is now stationed overseas.

Capt. Vincent Mazzanti, Little Rock, is now assigned to Medical Detachment, 383rd Infantry, Camp Beale, California.

Capt. M. W. Chastain, Bentonville, is now stationed overseas.

Capt. Hugh Mayfield, El Dorado, has received the bronze star for gallantry in action overseas.

Maj. W. D. Easterling, Lake Village, is now stationed overseas with a general hospital.

Maj. Rogers Hederick, Booneville, is now stationed overseas with a general hospital.

Dr. and Mrs. Virgil Payne, Pine Bluff, spent a recent vacation at Mobile.

Jack W. Kennedy, Prescott, has been ordered to active duty as lieutenant, Medical Corps, Army of the United States, and assigned to Carlisle Barracks, Pennsylvania.

Capt. Hollis Buckelew is now stationed at Custer General Hospital, Framingham, Massachusetts.

A. A. Blair and W. G. Eberle have been elected surgeons of the Victor Ellig Post, American Legion, at Fort Smith.

The Southeast Arkansas Medical Society was addressed July 17th at McGehee by Lt. Col. Dan H. Autry, Camp Robinson, on "Penicillin: Indications and Contraindications."

COMMUNIQUE

June 13, 1944

To the Editor:

Thanks for the letter, the news and the ballots. Had a visit with Binns from Monticello when I got clipped on the beach. After coming out of the hospital, I had a nice visit with Washburn. On returning to my outfit, I was promptly reassigned to a field hospital and have been following the front ever since. Our platoons leap frog each other keeping up and it's been rather hectic but Jerry is on the run now, so casualties are low. Was with the first hospital unit to set up in the big tent and was the second American doctor to operate there after the fall of the * * * show place. Too bad it couldn't be in the old tourist fashion. There's lots to be seen but will have to go back to see it now. Didn't get to see Fulmer but sent him greetings. My regards to all the boys and my thanks to you.

Ellery C. Gay, Major, M. C.

COMMUNIQUE

June 7, 1944

To the Editor:

Received the letter and April Journal; both were certainly appreciated. George Stocker must be somewhere nearby from the description he gives in The Journal. * * *

All we can say as to location is that we are the most distant base in * * *.

Have seen no Arkansas M. D's. as yet but surely will in the near future. Enjoy the Journals and the letters. Thanks.

Yours,

Richard W. Miller, Capt., M. C.

OBITUARY

MILTON CARR JOHN, age 67 years, died at his home in Stuttgart June 9th after a prolonged illness. Born in Cleveland County July 21, 1877, he attended the schools of the county and graduated from the University of the South. His medical degree was obtained from the University of Nashville Medical Department in 1903. He first located for practice at Moscow, Arkansas, and moved to Stuttgart in 1911. He was married to the former Miss Ida Fowler of Fordyce on January 3, 1904, who, with one son, Capt. Milton C. John, M. C., Army of the United States, in service overseas, one daughter, one sister and one brother, Dr. J. F. John, Eureka Springs, survives him. Active in organized medicine, he had served in the various offices of the Arkansas County Medical Society and in the Arkansas Medical Society. He served three terms as Councilor of the Arkansas Medical Society. He had been a member of the Board of Trustees of the Arkansas Tuberculosis Sanatorium and had served as a steward in the First Methodist Church of Stuttgart for 33 years.

COMMUNIQUE

July 16, 1944.

To the Editor:

Received your inquiry but really did not intend writing you until I found out definitely my destination from here.

My orders read to go to Brooks General Hospital at Fort Sam Houston, but from what information I get here, orders are often changed. I will probably get them here August 17th and will write you when I get located, which may be in Japan. Looks as though a good many from here will go to the South Pacific.

The work here isn't particularly hard, just continuous and no rest for the weary, but I am doing fine. I am acting first sergeant in our company. Counting dentists, veterinarians and nine negro doctors, there are 600 men in all, which makes a hot room when we are all together, and it has been just about as hot here as in Arkansas.

Regards,

Jack W. Kennedy, Lt., M. C.
57th OT Bn
Carlisle Barracks, Penn.

PRESIDENT'S REPORT OF THE 22ND ANNUAL MEETING OF WOMEN'S AUXILIARY TO THE AMERICAN MEDICAL ASSOCIATION

After spending a month in Indiana, I arrived in Chicago June 11th to attend the twenty-second annual meeting of the Woman's Auxiliary to the American Medical Association.

At 10 o'clock Monday morning the pre-convention board meeting was called to order by our National President, Mrs. Eben J. Carey, in the Towne Room of the Knickerbocker Hotel. At 12:30 we adjourned for the Board of Directors' luncheon, at which time I met officers and the other State Presidents. Discussion of their plans was inspirational and very interesting. The afternoon session was spent in the discussion of the revision of the Constitution and By-Laws. The main issue was the proposed amendment to create a board composed of the general officers and six elected directors to replace the former board of officers and State Presidents. The vote was 132 to 48 in favor of the amendment.

Mrs. Carey officially opened the general session on Tuesday morning, and throughout the convention she presided with poise and dignity. In addition to your president, Mrs. Charles Wallis, Little Rock, as delegate and Mrs. C. S. Early of Camden were the only ones attending from Arkansas. Invocation was by Rev. Joseph M. Egan, S. J., president of Loyola University. After Pledge of Allegiance to the Flag and the Pledge of Loyalty to the Auxiliary, greetings were extended by Dr. Bundunson. He gave as the three requisites of a good speech, "Be sincere, be brief, and be seated."

Mrs. M. A. Nix, Past-President Woman's Auxiliary to the Illinois State Medical Society, gave the address of welcome and the response was given by Mrs. Asher Yaguda, Past-President of the Woman's Auxiliary to the Medical Society of New Jersey. Both were outstanding in presentation and originality.

"In Memoriam" was impressive and beautifully given by Mrs. Mendenhall of Ft. Wayne, Ind. One hundred forty-one members passed away during the year. Mrs. Carey gave the President's Report and Mrs. David W. Thomas, President-Elect, was presented. Three hundred twenty members and guests attended a luncheon honoring the President, Mrs. Carey. Our guest speaker was Vice-Admiral Ross T. McIntire, Surgeon General U. S. Navy and personal physi-

cian to President Roosevelt. He spoke on "Women and the War" and was most generous in his praise of the contribution the women are making.

In the afternoon reports of officers and committee chairmen showed a great amount of work done with gratifying results. Mrs. Allen, organization chairman, reported 42 Auxiliaries with a paid membership of 24,480, a loss of 184 during the year.

A tea in honor of Mrs. Carey and Mrs. Thomas was held in the ballroom at 5:30.

At 8 p. m. the opening meeting of the House of Delegates of the American Medical Association was held in the Grand Ballroom of The Palmer House. This spacious room was filled to capacity to hear Dr. Kretschmer, President-Elect, American Medical Association.

Wednesday morning was given to business and the reports of officers. Time did not allow the State Presidents' reports, which were filed and are to be printed in an early issue of the Bulletin. A luncheon was given for the Past Presidents at 12:30 and each of them was presented with an orchid. At the luncheon officers were installed and Mrs. Thomas was presented with the President's pin.

Post-convention meeting was held Thursday morning when plans for the coming year were discussed and an inspiring message was given by Dr. Packard.

We adjourned to leave for our several states, having greatly benefited by the contacts and inspired to make our own state Auxiliary the best in the organization.

Mrs. A. C. (Elsie) Shipp,
President.

BOOK REVIEWS

Treatment of Peptic Ulcer: By Geo. J. Heuer, M. D., Professor of Surgery, Cornell University Medical College, etc. Pp. 118. Price, \$3.00—Philadelphia: J. B. Lippincott Company, 1944.

This 118 page book was compiled by Dr. George J. Heuer, Professor of Surgery at Cornell University.

The volume consists of a statistical review of 1,204 cases of peptic ulcer treated, both medically and surgically, at the New York Hospital. It is mainly a series of tables and explanations of tables covering each phase of the ulcer problem, for example: "Summary of all cases treated by Gastro-enterostomy," and again: "Secondary Operations for Ulcer." Under these and other headings the cases are given in numbers and percentages, with their improvement, progress and result, following which there is a commentary on this particular aspect. A review of the literature to date, and an author's discussion and summary, completes the book.

All in all this is a brief but complete, statistical but understandable presentation of all aspects of the treat-

ment of peptic ulcer. Each of us should read carefully this book for the same reason which prompted the author to write it. To quote the summary, "The reason which prompted our study was to discover . . . what we were accomplishing in the treatment of ulcer. It was hoped that . . . this might help in eliminating procedures which experience showed was of little value; that it might indicate what procedures were worth retaining; that it might suggest the procedures most appropriate in cases with complications, such as severe hemorrhages, pyloric obstruction, and marginal ulcer; and that it might define the limits of certain procedures as gastric resection.

The American Illustrated Medical Dictionary: By W. A. Newman Dorland, A. M., M. D., F. A. C. S., Lieut.-Colonel, M. R. C., U. S. Army; Member of the Committee on Nomenclature and Classification of Diseases of the American Medical Association; Editor of "American Pocket Medical Dictionary." With the Collaboration of E. C. L. Miller, M. D., Medical College of Virginia. Twentieth Edition, Revised and Enlarged. 1668 pages with 885 illustrations, including 240 portraits. Flexible and Stiff Binding. Philadelphia and London: W. B. Saunders Company, 1944. Plain \$7.00. Thumb-Indexed \$7.50.

This has been a deservedly popular work since the first edition appeared in 1900. Subsequent editions have maintained the authoritative position of the book by extensive revisions and additions in the light of changing medical nomenclature. A new edition at this time is welcome and a volume needed by every physician.

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1943: Cloth. Price, postpaid, \$1.00. Pp. 150. Chicago: American Medical Association, 1944.

The present volume of reprints contains only eight reports on rejected articles; it is interesting to note that objections to these are on a much higher plane than those it was necessary to urge against the flagrantly quackish preparations of earlier days.

Perhaps the most noteworthy of the nineteen general and "status" reports in this volume is the one declaring the Council's intention of using henceforth only the metric, or centimeter-gram-second system in its publications. The report itself gives some interesting and readable history on the subject of weights and measures. Of most timely interest to the general physician as well as the endocrine specialist is the report on nomenclature of endocrine preparations. The report gives a currently quite complete list of the available commercial preparations, including those not accepted by the Council as well as those which stand accepted. Another report in the field of endocrinology is that recognizing the use of estrogens in the treatment of prostatic carcinoma.

Attention should be called to at least two of the reports concerned with vitamin preparations, namely, the status report giving the Council's decision that the evidence does not yet warrant the acceptance of cod liver oil preparations for external use, and the report announcing the Council's recognition of the use of massive doses of Vitamin D in arthritis, and in this volume includes a current comment from The Journal titled "Hope (false) for the Victims of Arthritis," which re-emphasizes this objection.

The status report on xanthine compounds gives a much needed delimitation of the therapeutic claims that may be recognized for aminophylline and its related xanthine derivatives. Of similar interest is the report on the local use of sulfonamides in dermatology, and in the same

category may be mentioned the report on agents for the treatment of *Trichomonas Vaginitis*, which points out that the present aim should not be for new medicaments in this field but for further information, especially concerning failures with those that have been used. In another status report the Council sets forth its conclusion that present evidence does not justify claims for advantage of oral use of sodium sulfonamides over the free drug.

In line with its decision to consider for acceptance various contraceptive preparations, the Council published a status report on conception control, which is concluded in this volume. The report comprises a series of concise statements on the various preparations and methods of control, prepared by Dr. Robert Latou Dickinson, together with a statement of criteria by which the Council will consider the acceptability of contraceptive jellies, creams, and syringe applicators and nozzles, diaphragms and caps.

It cannot be too often said that this volume, as well as the other publications of the Council, remains of paramount interest to all who are concerned with rational use of therapeutic agents.

New and Nonofficial Remedies, 1944, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1944: Cloth. Price, postpaid, \$1.50. Pp. 778. Chicago: American Medical Association, 1944.

The current volume of *New and Nonofficial Remedies* reflects two important and forward looking decisions of the Council, namely, to use the metric system exclusively in all its publications, and to consider for acceptance contraceptive preparations offered for use as prescribed by physicians. These decisions in turn reflect the vigorous and progressive leadership of the Council in the service of Medicine.

The chapter on contraceptives is quite comprehensive; with the acceptance of more preparations, it will undoubtedly assume a large place in *New and Nonofficial Remedies*. The Council has thus far accepted some contraceptive jellies and creams, contraceptive diaphragms, diaphragm inserts, syringe applicators, and fitting rings. It is understood that a number of additional preparations have been submitted for Council consideration since the book went to press. This chapter represents a courageous and long-needed innovation.

Some of the new preparations that appear in this volume are: Succinylsulfathiazole, a new sulfonamide, a proprietary brand being "Sulfasuxidine"; Diodrast Concentrated Solution, a preparation of the already accepted Diodrast, for use in a special diagnostic procedure for visualization of the circulatory system and also cholangiography; a preparation of Sodium Benzoate for use as a liver function test; Mersalyl and Theophylline, accepted under the name Salyrgan-Theophylline Tablets, proposed as an adjunct to intravenous injection of the already accepted drug; Zinc Insulin Crystals and Zinc Insulin Injection Crystalline; Tetanus Toxoid; and Concentrated Oleo-vitamin A and D, a dosage of the pharmacopoeial preparation.

A glance at the preface shows that certain general articles have been revised to bring them up to date. More or less important revisions have been made of the following chapters: Barbituric Acid Derivatives, Estrogenic Substances; Parathyroid; Ovaries; Sulfonamide Compounds; Vitamins, especially the sections, Vitamin B Complex and Vitamin D. In this connection it is worth noting that each chapter in the book is reviewed annually, or more often if indicated, by the responsible referee for such revision.

This volume is of paramount interest to all those concerned with rational and modern drug therapy.

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A. L. CORNET, M. D., Department Director
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COUNTY SOCIETIES

1944

ARKANSAS MEDICAL SOCIETY

COUNTY	PRESIDENT	ADDRESS	SECRETARY	ADDRESS
ARKANSAS	M. C. John	Stuttgart	S. A. Drennen	Stuttgart
ASHLEY	M. C. Crandal	Wilmot	L. C. Barnes	Hamburg
BENTON	A. J. Harrison	Springdale	Geo. M. Love	Rogers
BOONE	M. E. Rust	Harrison	Ross Fowler	Harrison
BRADLEY	W. N. Roark	Hermitage	W. J. Hunt	Warren
CARROLL	A. L. Carter	Berryville	D. K. McCurry	Green Forest
CHICOT	B. C. Clark	Lake Village	M. K. Bottorff	Lake Village
CLARK	Chas. K. Townsend	Arkadelphia	Joe W. Reid	Arkadelphia
CLAY	N. J. Latimer	Corning	J. E. McGuire	Piggott
COLUMBIA	W. H. Horn	Magnolia	T. H. Jones	Waldo
CONWAY	J. H. Halbrook	Plumerville	T. W. Hardison	Morrilton
CRAIGHEAD-POINSETT	Ira W. Ellis	Monette	J. H. McCurry	Cash
CRAWFORD	F. A. Boomer	Van Buren	S. C. Grant	Mulberry
CRITTENDEN	T. S. Hare	Crawfordsville	L. C. McVay	Marion
CROSS	A. F. Barr	Cherry Valley	Thos. Wilson	Wynne
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LITTLE ROCK, ARKANSAS, SEPTEMBER, 1944

No. 4

MEDICOLEGAL ASPECTS OF PHYSICAL MEDICINE * †

CAPT. H. H. BUCKELEW

Medical Corps, Army of the United States
Little Rock

Malpractice may be likened to a disease in that it is endemic if not epidemic in distribution, and its incidence is increasing to such extent that it warrants consideration. It may be regarded as a contagious disease, in that the winning of an action almost invariably causes an increase in the number of claims in the locality. The predisposing factors are ethical instability or deficiency, carelessness and lack of forethought and tact. Symptoms of this disease are (1) tactless or careless medical personnel and (2) a disgruntled or dissatisfied patient with or without a just cause for complaint. The onset and course of this disease are legal matters and have a place beyond the scope of this discussion. The treatment, however, is another matter, and it is to this phase that discussion will be directed.

Treatment may be considered from the standpoints of (1) prevention and (2) specific management. Writing on this subject Regan stated: "Prevention is the best defense against malpractice, and making our ethics practical is the most important factor. The doctor must care for every patient with meticulous attention to the requirements of good practice and he must keep himself in position to prove that the standard demanded by law has been met in every case."¹

It is true that prevention is most important from every standpoint, for whenever a physician is brought to trial he is certain to lose, even if he wins the legal aspect. It is doubtful that the publicity attendant on litigation has ever been beneficial to the physician regardless of the outcome of the case.

* This work was done by Captain Buckelew while he was a student officer, under the direction of Dr. Frank H. Krusen, on temporary assignment in physical medicine at the Mayo Foundation, Rochester, Minn.

† Reprinted, by special permission, from Archives of Physical Therapy, June, 1944.

The following preventative measures are axiomatic in the realm of medicine, whether physical medicine or any other branch:

1. Physical Equipment:
 - a. Office impedimenta should be arranged to prevent accidents by stumbling or falling.
 - b. Radiators and other heating devices should be covered.
 - c. Exposed wiring in connection with electrical devices should be guarded.
 - d. Stairs, steps and other hazardous objects should have guard rails.
 - e. Adequate hoists and steps should be provided to prevent falls when the patient is getting into or onto treatment devices.
 - f. Lighting should be adequate.
 - g. Periodic inspection to see that all physical equipment is kept in good order and repair is necessary.
2. Records:
 - a. Complete and accurate records of the history, examination, diagnosis, treatment, progress and disposition of every case should be kept.
 - b. Records of consultations and advice to individual patients should be kept.
 - c. These records should be accurate as to dates, time and places.
3. Personnel:
 - a. Employees should be tactful and schooled in the wisdom of silence on matters which might create an unfavorable impression.
 - b. Employees should be properly trained in the application of treatment devices.
 - c. Employees must learn to investigate all complaints and have the judgment to call the responsible physician when there is question.
 - d. Employees should assist the patient in all movements and remain within earshot while the patient is under treatment.
4. Management:
 - a. Meticulous attention to the requirements

of good practice must be given in each case.

- b. Experimentation with hazardous equipment should be avoided.
 - c. The physician should be specific in prescribing treatment to be given by an employee, but should train the employee to use good judgment in carrying out orders.
 - d. The laboratory should be used when indicated.
 - e. Care should be used in accepting the judgment of others. It is surprising how often physicians confuse ultraviolet and infra-red ray therapy.
5. Tact:
- a. It should be recognized that the sensibilities of an ill person are in a state of imbalance.
 - b. The physician must remember that the patient is in better position to know what he feels, smells, tastes and so forth than the physician can ever be.
 - c. A little psychotherapy goes well with any other treatment.
 - d. "See no evil, hear no evil and speak no evil" should be followed when other members of the medical profession are concerned.
 - e. It is not enough that the physician is right. He must convince the patient that he is right.

Many other points might be mentioned for the sake of completeness, but a review of malpractice cases over the past twenty years indicates that application of the principles mentioned would have forestalled most of them. It is not at all difficult to find practical examples in abstracts of medicolegal cases to demonstrate the wisdom of these principles.

Illustrative Cases

I shall mention three cases in which physical equipment was involved:

In the case of *Hoover vs. Goss* (Washington)² the defendant physician had finished a local treatment and the patient was told to remain on the treatment table until she felt all right. She got up immediately after the physician left the room, fainted, fell on a radiator and was burned. The case was dismissed only after much litigation. In the case of *Saltzer vs. Reckard* (Pennsylvania)³ the plaintiff, after recovering from an illness, was visiting in the physician's office. While there he complained of feeling faint. The physician assisted him to a stool and told him to lower his head. He fell, upsetting a sterilizer of boiling

water, and received a severe burn. The jury awarded the plaintiff \$5,000. The supreme court finally reversed the decision. A third case involved a roentgenologist who had not kept his equipment in good repair. A bracket came loose while a roentgenogram was being taken, a portion of the apparatus fell and the patient's nose was broken. The jury held for the plaintiff.

The case of *Cappell vs. Jones* (New Jersey)⁴ illustrates the necessity of the attendant's remaining within earshot. During the application of heating pads to the calf of the patient's leg, the nurse employee left the room for twenty minutes. The patient was burned. The courts finally held for the plaintiff.

The defendant physician does not profit if his employees remain within earshot of the patient unless complaints are investigated. In the case of *Sima vs. Wright* (Michigan)⁵ the plaintiff sued the physician for burns alleged to have been caused by a diathermy treatment. In his complaint, the plaintiff stated that two minutes after the plates had been applied to his back, he complained of heat to the nurse employee. She made no investigation. A few minutes later, he complained again, only to be ignored. When the physician finally removed the plates, the plaintiff testified that he could smell burned tissue. The jury held for the plaintiff.

The case of *Grubbs v. McShane* (Florida)⁶ illustrates the value of care and tact in giving instructions for the home treatment of patients. The patient had had an abdominal operation, and phlebitis had developed after she had gone home. The physician had instructed a lay member of the family in the manner of building and the use of a heat cradle made of barrel staves and electrical fixtures. The patient received blisters and complained to the physician, who insisted that the cradle be left intact and that the number of light bulbs be decreased. A suit developed later. The case was defeated only after expert testimony had shown that the blisters might have been caused by the phlebitis.

That care should be used in accepting the judgment of others is demonstrated in the case of *Krumeich vs. Sundelson* (New York).⁷ The patient presented the physical therapy physician with a prescription for ultraviolet light, reading seven minutes at 27 inches (68.5 cm.). The defendant applied the light seven minutes at 6 inches (15 cm.). The jury presented the plaintiff with a favorable decision.

There is no excuse for the physician to fail to use good clinical judgment. In the case of *McCullough vs. Langer* (California)⁸ a crushing,

bruising injury to the flesh of the left thigh was treated by packs after an opiate had been administered. Towels wrung out of saline solution and covered by a rubber sheet and a dry towel were applied and kept hot by a 500-watt infra-red lamp at 21 inches (53 cm.) for four hours. The patient went to sleep, and when the pack was removed a third degree burn was present which subsequently removed \$25,000 from the doctor.

The need for attention to minor details is dramatized by a case⁹ in which a patient was receiving diathermy for a bruise on the cheek. She was wisely advised to report if she felt a burning sensation. She testified at the suit that she reported a "tingling" sensation several times to the physician, who probably forgot that devitalized tissue and some anesthesia were present. The failure to investigate, and the fact that a burn was sustained from the machine, which experts said was capable of causing a burn and capable of being controlled, lost the suit for the physician.

In a review of the foregoing cases, it is impossible to gather all of the factors that enter into a malpractice suit. The elements of personalities, careless words and tactless acts are all submerged between the lines of legal phraseology. Nor is it possible ever to read that the harassed doctor was tired, overworked and mentally exhausted. Suffice it to say that in any case an ounce of prevention would have been worth a pound of cure.

Defense Against Malpractice Suits

Defense might be considered the specific treatment against the malpractice "disease." In legal language, a defense is a full answer to the whole or to some part of the plaintiff's demand. In the language of the physician, it is that which is offered to show why the plaintiff should not establish what he seeks. It is intended to defeat the action.

When a physician is confronted with a suit, his wisest action, in most cases, is to settle the matter out of court if this case can be done without too great sacrifice. Assuming that in a given case the physician determines to let the matter go to trial, that is, to let the matter be settled by "twelve men, good and true," either he can acknowledge the allegations in the complaint or he can deny them and assert that the plaintiff has no grounds for action. I shall make no comment on the first method. If the physician denies the allegations of the plaintiff, the burden of proof will then lie on the plaintiff to show lack of skill or want of care. Furthermore, in many cases the plaintiff will be required to show by expert witness wherein the doctor failed to exercise ordinary skill and care common to the locality. The

evidence of expert witnesses is often dispensed with in the realm of physical medicine, because courts have held repeatedly that any witness can testify to that which he sees and knows. So often in physical medicine the act or instrument of its use speaks for itself (*res ipsa loquitur*). Nearly all of the implements of the physical therapy physician are capable of producing injury. All of these implements are capable of being controlled to prevent injury. Therefore, if injury results from their use, it may be inferred that ordinary skill and care were not used in their application.

What then is the physician's line of defense? Discussion of such technical defenses as jurisdiction, abatement, *res judicata* and statute of limitations have no place here. They are the armamentarium of the attorney, which the physician must surely employ. There are three elements of the defense that are the responsibility of the defendant physician. These are as follows (1) complete and accurate records referable to the case—these should be honest records without the taint of "doctoring"; (2) the names of eyewitnesses who will testify in the case, and (3) the names of consultants or other members of the medical profession who will testify as to the adequacy of skill and care. Beyond this the physician should be prepared to defend his judgment from every possible line of attack. His attitude should be one of calmness, humility and simplicity.

Perhaps it would be well, while I am on the matter of defense, to discuss some of the basic considerations in the matter of evidence. In reading abstracts of medicolegal cases, one frequently encounters the phrase *res ipsa loquitur*, which was referred to briefly before. In its application to physical medicine, the best definition is "the thing speaks for itself." When this rule of evidence is invoked, it creates either a presumption or an inference of negligence. The Supreme Court of the United States,¹⁰ commenting on this rule many years ago, stated:

"When a thing which causes injury without fault of the injured person is shown to be under the exclusive control of the defendant, and the injury is such as in the ordinary course of things, does not occur if the one having control uses proper care, it affords reasonable evidence, in the absence, of explanation, that the injury arose from the defendant's want of care."

Prominence has been given this rule because of its obvious application to physical medicine. States vary in their philosophies concerning malpractice. Almost every rule and philosophy known to law applied to malpractice is found in a review of these cases. One particularly vicious

doctrine is encountered often enough to cause comment here. This is known as the "loaned servant doctrine." This doctrine holds that the servant of an employer can be loaned or hired to another employer for a particular piece of work, and that the servant then becomes the employee of the borrower, who accepts the responsibility for his acts. The case of *Bishop vs. Drs. A and H of Oklahoma*¹¹ illustrates the application of this doctrine. While Bishop was undergoing surgical intervention by Drs. A and H, a pan of hot water was placed between his feet by a nurse who was regularly employed by the hospital but was assisting in the operating room at the time. Thus, the court held, the nurse was temporarily "loaned" to Drs. A and H, who were responsible for her acts. By application of the "loaned servant doctrine" the physicians were held liable. Justice William H. Taft commented many years ago that few would be courageous enough to practice the healing art if this doctrine were applied often. However, it cannot be denied that its use has become more prominent in recent years.

In concluding this discussion, it is well to consider again those classic remarks of the Supreme Court of Missouri in discussing what the law demands of a physician:¹²

"The law exacts of a physician and surgeon who undertakes to treat a patient that he (1) possesses that degree of skill and learning which is ordinarily possessed and exercised by the members of his profession in good standing, practicing in similar localities; (2) use reasonable care and diligence in the exercise of skill and the application of his learning, and (3) act according to his best judgment. Conversely he is liable for an injury to his patient resulting from want of the requisite knowledge and skill, or the omission to exercise reasonable care or the failure to use his best judgment."

And, I might add, be prepared to prove that you have met these requirements.

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COMMUNIQUE

August 4, 1944.

To the Editor:

I haven't had much time for writing since I have been in the Army, but I do want to express my heartfelt thanks to you for the interesting letters you have put out for us all and the effort you have made to keep us all informed of the various happenings and movements of our friends. I can assure you that it is a decided help to morale, whether you are in this country or on foreign duty, to receive your letters. It makes us feel as though there is a home front.

In one of your letters you expressed yourself as being proud of the way the members of our Arkansas Medical Society have responded to this emergency. I am proud, too, and feel that all the work isn't being done in the Army. You boys at home are catching plenty of hell, I know, because I know some of the civilian doctors here in Pampa.

Although the last chapter in this war is still to be written, they seem to have gotten along very well in all the theaters of operation. As you know, I have spent my entire time in Texas and think I deserve a service ribbon for the same. However, I want to go on record as saying that the more I see of my native state of Texas the better I like Arkansas. I will be looking forward to the day when I can get back home.

Give my regards to all the boys.

Sincerely,

Euclid M. Smith, Maj., M. C.
Station Hospital,
Pampa Army Air Field,
Pampa, Texas.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

THE protection and education of children is universally conceded to be one of the primary functions of the modern state. In the realm of public health, especially that part which concerns itself with the control of tuberculosis, this function has been translated into the well-accepted principle that no person with positive sputum should be allowed to remain in a household where there are children. Too long, however, the danger of tuberculosis among school personnel has been overlooked, although the school ranks immediately after the home in importance in the life of a child.

TUBERCULOSIS IN SCHOOLS

The Legislative Assembly of the Province of Quebec on May 17, 1941, unanimously passed an act stating that no person could teach in a public, private or independent school unless he produces every year a physician's certificate stating that he "suffers from no infirmity or disease which renders him unfit for teaching" and "a certificate from a phthisiologist attesting that a clinical and radiological pulmonary examination shows that such person is free from tuberculous disease." Such examination must be made within two months following the engagement. Should any teacher prove to be tuberculous the contract to teach is immediately rescinded.

If Quebec glories in being the first province in Canada to pass such a law it must be admitted that it is the one to need it most—having the highest death rate from tuberculosis among the Canadian provinces. Three factors led to the passage of the law. First, a three-year educational campaign on tuberculosis which reached most of the population; second, a law passed by the city of Quebec requiring all teachers of the School Commission to undergo examination for tuberculosis, including a chest X-ray. Out of 523 teachers examined 16 were withdrawn from teaching because of active or chronic tuberculosis. The third factor was a personal experience published in an educational review which demonstrated mass contamination of pupils by a tuberculous teacher.

The legislation was introduced by the Council of Education of which all the bishops of the Province are members, so the doors of the teaching religious congregations were thrown open.

Difficulties arose in the enforcement of this new law as was to be expected, but these were overcome as the organization proceeded. In rural districts the expense was borne by the Board of Health, in Montreal the Catholic and Protestant school commissions paid for the X-ray films.

The results of the examination of 16,524 teachers in the Province of Quebec, with the exception of the city of Montreal, are shown in Table I.

Table I

Examination of school teachers for tuberculosis.
All the Province of Quebec except the City of Montreal.

Type of teacher	Number of teachers examined	Number of teachers rejected for tuberculosis ¹	Per cent of total examined rejected for tuberculosis
Total	16,524	212	1.3
Females	13,553	178	1.3
Religious	6,152	115	1.9
Lay	7,401	63	0.9
Males	2,971	34	1.1
Religious	2,155	27	1.3
Lay	816	7	0.9

¹ Includes some persons with non-active disease and some under observation.

It is apparent that tuberculosis was twice as prevalent among religious teachers as it was among the lay teachers, even though most of the religious congregations have required, for the past few years, an X-ray examination of the chest from all applicants for admission to their groups.

Table II

Examination of school teachers for tuberculosis.
City of Montreal—Catholic School Commission

Type of teacher	Number of teachers examined	Number of teachers rejected for tuberculosis ¹	Per cent of total examined rejected for tuberculosis
Total	4,695	15	0.32
Females	2,785	9	0.32
Religious	1,879	3	0.16
Lay	906	6	0.66
Males	1,910	6	0.31
Religious	762
Lay	1,148	6	0.52

¹ Includes only active cases.

In the city of Montreal, the results of examination for tuberculosis do not show the same trend. According to Dr. Laberge, the report was not complete for the religious teachers. The data from the Catholic School Commission are summarized in Table II.

The Protestant School Commission reported 1,533 teachers X-rayed, only one of whom was rejected.

Detection of Tuberculosis in School Teachers in the Province of Quebec, L. Laberge, M. D., Canadian Journal of Public Health, March, 1943.

During August, 1939, an act passed by the Senate and General Assembly of New Jersey provided that the Board of Education of every school district should periodically determine the presence or absence of active tuberculosis in any or all pupils in public schools. The rules and regulations for complying with this were to be made by the State Board of Education. Any pupil found with active tuberculosis was to be excluded from school until the disease was no longer communicable. Employees (which includes teachers) of boards of education were required to have a physical examination by the provisions of a similar act passed at the same time. The State Board of Education was to determine the scope of such an examination.

The State Board of Education on May 11, 1940, ruled that all pupils of grades nine, ten, eleven and twelve and all special students enrolled in high school should be listed or examined annually, as early as possible in each school year. For employees the board ruled that the examination was to be limited to determination of the presence or absence of tuberculosis.

This legislation was the climax of a long term program of health education in homes, schools and community groups in New Jersey. Parents, children and school personnel were ready for the

step when it was taken so there was no serious opposition in any county. The examinations themselves were used as an educational demonstration and great care was used to prepare pupils for them. It is now recommended that discussion with pupils should follow the testing. Answering students' questions and explaining the results in classrooms or individually will do much to give the procedure meaning.

X-ray examinations of the students who were positive reactors, and of a few students who were not tuberculin tested, revealed 343 cases of reinfection type tuberculosis, or approximately 2 per 1,000. Of the 2,772 teachers examined, 67 or 2.4 per cent had reinfection tuberculosis. Of these, 31 were classified as stable.

Reports on the disposition of reinfection type tuberculosis were incomplete. However, 23 cases were hospitalized, 21 cases excluded from schools, 2 deaths shortly after examination and 40 students and employees permitted to return to school under medical supervision with periodic X-rays.

Out of 195,130 students in New Jersey schools during 1941-42, 19.9 per cent were positive reactors to the tuberculin test. Of 59,736 who were tested for the first time, 13.8 per cent were positive reactors. Retests of 99,964 students who were negative reactors in previous years yielded 10.7 per cent positive reactors. This group is highly significant from the standpoint of epidemiological control. Its members have been recently in contact with an infection source. The prevailing infection rate in the school population therefore is slightly less than 20 per cent. Among teacher and employee groups 39.7 per cent were positive reactors. Other significant chest, heart and orthopedic conditions were revealed by the school tuberculin testing and X-raying program.

Tuberculosis Control in the Schools of New Jersey, compiled by the N. J. Tuberculosis League, co-operating with the State Dept. of Pub. Instr., January, 1944.

COMMUNIQUE

August 1, 1944.

To the Editor:

Just a short note to advise you of a change of address as above. I left * * * about a month ago and finally wound up here. Have been very busy since being here, seeing many patients, and working seven days a week. I didn't get to see Krock on my way up though have heard indirectly from him several times lately by men recently in contact with him and apparently he is quite busy, too. Give my regards to all the gang.

R. J. Calcote, Comdr., M. C.

U. S. N. R.

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EDITORIALS

DISTRIBUTION OF PHYSICIANS IN
ARKANSAS

Elsewhere in this issue are published figures
compiled by the Procurement and Assignment
Service in Arkansas as of August 15, 1944, giv-
ing the number of physicians and the number of
active physicians in each county of the state, to-
gether with the ratio of physicians to population.
A study of these figures is of considerable inter-
est to the profession and to the public. With
the generally accepted ratio of one physician to
1,500 population, it is noted that the over-all
state ratio is 1 to 1,578 while 23 counties have
this approximate ratio. Thirteen counties have
a ratio of one physician to 1,000 to 1,400 popu-
lation. Thirty-eight counties have ratios of 1,750
to 3,000 population per physician. In three
counties the ratio is more than 3,000 population
per physician. In but three counties is the ratio
lower than one physician to 1,000 population.
The figures as presented are subject to analysis
from several viewpoints, notably density of popu-
lation, economic factors, and the influence of
hospital and other treatment centers upon the
number of physicians within a given area. The

table deserves the consideration of the profes-
sion with the present active discussions over the
availability of medical care to the citizens high-
lighting a scarcity of physicians in rural commu-
nities.

THE HOLLINGSWORTH HOSPITAL ACT

The Hollingsworth Hospital Act, whose spon-
sors remain relatively anonymous, will be submit-
ted to Arkansas voters at the general election to
be held November 7, 1944. This act provides
for (1) the creation of a system of hospitals
throughout the state for the purpose of providing
hospitalization to all residents of the state on a
"balance of cost" basis; (2) the raising of funds
by taxation for the building, equipping, furnish-
ing, maintaining and operating of such hospitals
and for the construction of a Medical Research
department in Little Rock, which building shall
also house the administrative officials and em-
ployees of the system; (3) the appointment by
the governor of a self-perpetuating commission
of three members to administer the system, and
(4) an appropriation of \$5,000,000 for each of
the years ending February 15, 1946 and 1947.
The system is created for a period of 99 years.
Revenues for operation of the system are to be
raised by levying taxes on the following: Lumber,
petroleum, coal, ores, stone, marble, sand and
gravel, clay, sulphur, and electric current.

Reasons for defeat of this act seem obvious.
The building, maintaining and operation of such
an elaborate system (five general hospitals and
a county hospital in each county) would seriously
impair the economic stability of the state. No
convincing reasons have been shown for the es-
tablishment of such a system of hospitalization
in the state. There exists necessary authority
for counties to levy a five-mill property tax for
construction of hospitals where such hospitals
may be desired by the citizens. The act provides
for a separate tax collection machinery, dupli-
cating expenses in this field. At this time, it is
extremely doubtful if even one hospital could be
completed and placed in operation within the
next two years. Yet, the act would appropriate
\$2,400,000 for general expense and \$1,400,000
for salaries in this period to operate a virtually
non-existent hospital system. The act is virtually
confiscatory to the private and voluntary hos-
pitals of the state who have so well provided hos-
pital care to our people for these many years.
These interests should be encouraged to amplify
hospital facilities in the state on a private enter-

prise basis with state support being given in the form of payments for the care of the indigent population. The physicians of the state are urged to familiarize themselves with the provisions of this bill and to acquaint their patients and associates with its undesirable implications.

RANDOM THOUGHTS OF THE SECRETARY

July 24th. Thanks to Porter for Stars and Stripes; to Richardson for C.B.I. Roundup; to Hanchey for 7th A.A.F. Briefs, the first slick paper service paper we have seen and really something to be proud of in competition with commercial magazines, and to Smallwood, who continues to help us keep in touch with all those army medical officers who cannot think to send us notice of change of station.

July 26th. The "outs" took the "ins" out yesterday and several local political sages of our acquaintance find themselves without an explanation.

August 4th. Seigel graciously permits us to enjoy life as do the good people of Johnson County at this season by shipping us a bushel of those famed Johnson County Elbertas.

August 8th. Bob Robins should feel that his efforts to induce doctors to take part in politics are producing—never before have we seen so many doctors' names in print extolling candidates.

August 9th. With visits to Hawaii and to the Aleutians, we venture the prophecy that the Commander-in-Chief makes a fireside talk from Paris before November 1st.

August 10th. Amis returns and we revisit Burns Gables where host and hostess turn the place inside out for the Commander in a hilarious evening.

August 10th. Imagine the relief of MacArthur and Nimitz now that they have received needed strategy suggestions.

August 13th. Pleased with a visit from the Foltz' today, renewing the happy "drop-in" visits of peacetime with Foltz, commendably reticent over his exploits and achievements in the Induction Center.

August 14th. Comes an intricately-made fan from Hanchey which he says is of native handicraft. Recalling previous correspondence in which Hanchey stated that he could build most anything out of beachcombing materials, we merely pause to wonder if he has gone native.

August 15th. By air in gusty flying weather to Little Rock where the Hollingsworth Act becomes the subject for business and professional interests in conference and comprehensive plans are laid for education of the electorate prior to the November election.

DISTRIBUTION OF PHYSICIANS BY COUNTIES IN ARKANSAS

COUNTY	Population 11-1-43	8-15-44 Total Physicians	8-15-44 Total Active Physicians	Ratio Population to Active Physicians
Arkansas	22,654	14	10	2,265
Ashley	24,630	18	16	1,539
Baxter	9,823	9	9	1,091
Benton	30,177	29	23	1,312
Boone	13,555	11	9	1,506
Bradley	14,690	10	9	1,632
Calhoun	7,525	6	3	2,508

Carroll	10,979	10	8	1,383
Chicot	25,568	15	13	1,966
Clark	20,837	11	10	2,084
Clay	24,901	17	13	1,915
Cleburne	10,534	8	6	1,756
Cleveland	9,750	5	5	1,950
Columbia	26,218	19	18	1,457
Conway	16,687	9	7	2,383
Craighead	42,835	31	28	1,530
Crawford	20,662	15	14	1,476
Crittenden	40,209	15	15	2,680
Cross	24,662	11	11	2,242
Dallas	11,715	8	8	1,464
Desha	31,843	12	11	2,895
Drew	21,191	13	10	2,119
Faulkner	21,770	25	19	1,145
Franklin	11,405	8	8	1,426
Fulton	7,467	5	5	1,493
Garland	37,888	69	48	789
Grant	9,109	4	4	2,277
Greene	24,282	14	14	1,734
Hempstead	26,327	10	9	2,925
Hot Spring	17,540	13	11	1,595
Howard	12,895	13	7	1,842
Independence	20,156	12	12	1,679
Izard	10,062	4	3	3,354
Jackson	23,974	18	15	1,598
Jefferson	72,752	41	35	2,078
Johnson	13,221	7	7	1,888
Lafayette	14,074	13	13	1,083
Lawrence	20,332	15	12	1,694
Lee	23,661	10	7	3,380
Lincoln	17,189	7	7	2,456
Little River	12,349	6	5	2,470
Logan	19,961	25	25	798
Lonoke	27,229	15	9	3,026
Madison	11,633	7	6	1,939
Marion	6,762	5	4	1,691
Miller	30,015	25	24	1,251
Mississippi	77,558	36	35	2,215
Monroe	18,153	11	9	2,017
Montgomery	6,242	5	5	1,258
Nevada	15,479	9	6	2,579
Newton	7,908	2	2	3,954
Ouachita	27,714	20	16	1,732
Perry	6,042	4	3	2,014
Phillips	41,732	27	21	1,987
Pike	9,689	6	6	1,615
Poinsett	35,454	17	16	2,216
Polk	12,409	11	10	1,241
Pope	18,919	20	18	1,051
Prairie	12,883	8	8	1,610
Pulaski	165,771	221	185	896
Randolph	14,093	10	9	1,566
St. Francis	33,163	17	16	2,073
Saline	23,483	10	8	2,935
Scott	9,695	8	7	1,385
Searcy	9,412	9	7	1,177
Sebastian	58,253	56	45	1,294
Sevier	11,790	11	8	1,474
Sharp	9,038	5	5	1,808
Stone	6,612	3	2	3,306
Union	45,629	34	22	2,074
Van Buren	9,099	7	4	2,277
Washington	31,327	33	24	1,305
White	31,862	25	22	1,448
Woodruff	18,564	13	7	2,652
Yell	13,893	11	8	1,736
Totals	1,735,564	1,316	1,099	1,578

THE 1944 PLATFORMS OF THE DEMOCRATIC AND REPUBLICAN PARTIES ON SECURITY

Here are the planks in the Democratic platform that refer directly or indirectly to a health program:

"Beginning March, 1933, the Democratic Administration . . . provided social security, including old age pensions, unemployment insurance, security for crippled and dependent children and the blind. . . . We pledge the continuance and improvement of these programs.

* * *

"We offer these postwar programs:

"A continuation of our policy of full benefits for ex-servicemen and women with special consideration for the disabled. . . .

"The enactment of such additional humanitarian, labor, social and farm legislation as time and experience may require, including the amendment or repeal of any law enacted in recent years which has failed to accomplish its purpose.

* * *

"We reassert our faith in competitive private enterprise free from control by monopolies, cartels, or any arbitrary private or public authority."

Republican

Our goal is to prevent hardship and poverty

in America. That goal is attainable by reason of the productive ability of free American labor, industry, and agriculture, if supplemented by a system of social security on sound principles.

We pledge our support of the following:

1. Extension of the existing old-age insurance and unemployment insurance systems to all employees not already covered.

2. The return of the public employment-office system to the States at the earliest possible time, financed as before Pearl Harbor.

3. A careful study of Federal-State programs for maternal and child health, dependent children, and assistance to the blind, with a view to strengthening these programs.

4. The continuation of these and other programs relating to health, and the stimulation by Federal aid of State plans to make medical and hospital service available to those in need without disturbing doctor-patient relationships or socializing medicine.

5. The stimulation of State and local plans to provide decent low-cost housing properly financed by the Federal Housing Administration, or otherwise, when such housing cannot be supplied or financed by private sources.

COMMUNIQUE

July 19, 1944.

To the Editor:

Battle casualties keep pouring in. We have been extremely busy for the past three months, functioning as an evacuation hospital. The excellent esprit de corps among the * * * wounded soldiers is amazing. The number of wounded officers is high, much higher than statistics would indicate for other armies. Most of the soldiers are most grateful for the supplementary food rations we put out. In spite of the rapid turnover in patients we keep many here long enough to get them back to duty in the front lines. We are surprised to find practically no signs of psychoneurosis among the casualties.

There are times when we think this is a very rugged, tough life. Food not much to our liking, rice and more rice with "C" rations. Occasionally we get meat and vegetables from a distant market. But compared to the more advanced units we are most fortunate. One of my hospital units was bombed a few weeks ago. Since then we have dispersed the ward tents as widely as possible. It's quite a task transporting the patients from ward to ward in drenching rains.

We have encountered some tetanus and several cases of gas gangrene. All are responding well to treatment. **Do you advocate the use of X-ray in treating gas gangrene? It seems to have been effective in our seven cases.** (Editorial emphasis.)

On a recent visit down the line I happened to meet Causey. I had invited him to stop for a visit with me, but he had been unable to do so. He found mountain climbing a little too hard on his feet, and is now doing a lot of surgery in a nearby evacuation hospital. We enjoyed talking about Arkansas, past medical meetings, Earle Hunt's jokes, etc. We have been receiving The Journal and your "Random Thots" quite regularly. Glad that you liked the CBI Roundup. I think it is okay. I'll send another copy before long.

Ours was the first complete medical unit to arrive in * * *. With 15 months behind us we are already counting the days, although we haven't any great hopes that either the 18 months or the two years bill will apply here. After all, we are at the end of the line. Still, it's nice to speculate.

Appreciated your personal letter. Thanks.

Sincerely,

Robert H. Johnston, Maj., M. C.

THE ANNUAL FALL CONFERENCE OF THE KANSAS CITY SOUTHWEST CLINICAL SOCIETY

The dates of the Annual Fall Clinical Conference of the Kansas City Southwest Clinical Society are October 2, 3, 4, 1944.

The Broadside issue of the Kansas City Medical Journal carries the list of distinguished guest speakers, scientific presentations and program of symposia to be presented by members of the society.

The meeting will open with a Round Table Discussion, directed by Dr. Ira H. Lockwood, and devoted to the newer things in medicine as portrayed by the participating guest speakers.

Symposia on the following systems will be presented, three each Tuesday and Wednesday morning: gastrointestinal, obstetrics, pediatrics, cardiovascular, urogenital, headache and backache. These will be presented in rooms with ample seating capacity for all of the registrants.

Scientific presentations by the guest speakers will be made before the general assemblies each day. The meeting on Tuesday evening will be a joint one with the county medical societies. Dr. Frank H. Lahey, Boston, will be the speaker for this meeting. His message will be "Medicine Today, In and Out of the Service and After the War."

A copy of the Kansas City Medical Journal will be sent you upon request—208 Shukert Bldg., Kansas City 6, Mo.

THE PHYSICIAN'S IMPORTANCE IN WAR AND PEACE

To memorialize the medical profession's "skill and courage and devotion beyond the call of duty" is the purpose of the new prize-contest recently announced by the American Physicians Art Association.

The contest is open to all physicians, both civilian and military, who are members of the A. P. A. A. The prizes are sufficiently important to attract some very fine art in all of the principal media, including oil, water color, sculpture, and photography.

For full details, write to the Association's Secretary, Dr. F. H. Redewill, Flood Bldg., San Francisco, Cal. Also pass this information on to your physician-artist friends, both civilian and military.

FOR SALE: Full office equipment and supplies of the late Dr. W. G. Allison. Write Mrs. W. G. Allison, Hope, Arkansas.

PERSONALS AND NEWS ITEMS

Maj. Glenn G. Hairston, Prescott, is now stationed overseas with an armored division.

Capt. Elmer G. Burt, Crossett, is now assigned to Station Hospital, Camp Carson, Colorado.

Capt. William J. Butt, Fayetteville, is now stationed overseas.

Maj. John W. Smith, Little Rock, has returned from service overseas and is stationed at Miami Beach, Florida.

Maj. Chas. H. Reagan, Marked Tree, has been assigned to the 122nd Evacuation Hospital, Camp Brackenridge, Kentucky.

J. T. Wood has moved from Crossett to Fountain Hill.

Ira Ellis, Monette, T. G. Porter, Hazen, and J. O. Rush, Forrest City, attended the Southern Pediatric Seminar in Saluda, North Carolina, during July.

Mahlon D. Prickett has accepted a residency at the University of Iowa Hospital, Iowa City.

Capt. Guy P. Shrigley, Clarksville, is now stationed overseas with a station hospital.

D. W. Goldstein has been appointed Venereal Disease Consultant to the Fort Smith District Health Department.

H. W. Savery has been elected post surgeon of the Van Buren Post of the American Legion.

J. S. Miller has been elected post surgeon of the Wynne Post of the American Legion.

A. D. Cathey has been elected post surgeon of the El Dorado Post of the American Legion.

I. J. Spitzberg has been elected medic of the Little Rock Voiture, Forty and Eight.

O. L. Atkinson, Hampton, has been elected commander, Calhoun County American Legion Post No. 50.

Lt. Thomas L. Adair, Bald Knob, is now stationed with the ASF at Fort Francis E. Warren, Wyoming.

Lt. Col. John W. Dorman, Dyess, is now stationed overseas.

Lt. Leslie G. Holt, Little Rock, is now stationed overseas with a general hospital.

R. B. Robins, Camden, recently addressed the Union County Medical Society on "Politics."

Dr. and Mrs. B. A. Rhinehart, Little Rock, spent a recent vacation in Minnesota and Canada.

F. Q. Wyatt has been elected surgeon of the Batesville Post of the American Legion.

J. Rex Williams has been elected surgeon of the Siloam Springs Post of the American Legion.

Miles F. Kelly, Sheridan, has been retired from service as Captain, Medical Corps, Army of the United States, and has returned home.

"Indications for Pelvioscopy in the Female" by Maj. Wm. B. Harrell, Little Rock, and Rafael Estevez, Republic de Panama, appeared in the Southern Medical Journal for August.

Capt. H. V. Kirby, Harrison, has received the bronze star for achievement on a battle front.

Frank M. Adams, Hot Springs National Park, now stationed with the 168th General Hospital, Camp Grant, Illinois, has been promoted to major.

Dr. and Mrs. R. B. Robins, Camden, spent a recent vacation at Rockaway Beach, Missouri.

W. H. Martin, Holly Grove, has been appointed part-time venereal disease clinician for the Monroe County Health Unit.

E. J. Horner has been elected surgeon of the Jonesboro post of the American Legion.

"The Relative Importance of the Anatomic and Physiologic Concept in Tuberculosis," by J. D. Riley, State Sanatorium, appeared in Disease of the Chest, July-August issue.

Lt. John P. Eaton, Little Rock, is now stationed at Warner Robins Field, Georgia.

Capt. Marvin B. Crow, Warren, is now stationed at Bruns General Hospital, Santa Fe, New Mexico.

Belle D. Poole, El Dorado, has moved to Pasadena, California.

"American Health Resorts: Treatment of Conditions Affecting the General Nervous System," by George B. Fletcher, Hot Springs National Park, appeared in The Journal of the American Medical Association, August 12, 1944.

COMMUNIQUE

July 8, 1944.

To the Editor:

An irregular unofficial meeting of the Hempstead County Medical Society was held July 2, 1944, at 16:30 double summer *** time in the barracks of Maj. James G. Martindale and Capt. Jim McKenzie. Members present were: Lt. Col. James W. Branch, Maj. James G. Martindale and Capt. Jim McKenzie. Members absent were: Drs. G. E. Cannon, P. B. Carrigan, J. E. Gentry, H. G. Heller, L. M. Lile and Don Smith. An official visitor at the meeting was Capt. Royce Weisenberger, former state representative from Hope. Since there was not a quorum present, no official business was transacted, but a very good time was had by all discussing the days when the practice of medicine was in flower. Following the meeting the members, with the exception of Major Martindale, adjourned to Capt. McKenzie's base where a good supper with two kinds of ice cream and chocolate cake was enjoyed by all, especially by Capt. Weisenberger, as this was his first ice cream in over six months.

It seems quite a coincidence that the three of us from Hope who are in the Army would be over here and be able to get together. Major Martindale is located only about twelve miles from here. I also went up to see Capt. Jack Ellis from Hot Springs about two weeks ago.

After talking with Col. Branch, Maj. Martindale and Capt. Ellis, I would not say what a wonderful job the Arkansas boys are doing over here and how busy we are, but would say that the three of them look anything but overworked and underfed and I would certainly be afraid to take a deep breath in one of my civilian suits.

Would you please change my APO from ** to **. The first part is still the same but I get my mail a day or two sooner if addressed to the new APO.

Received the June issue of The Journal this week and enjoyed it as usual.

Sincerely,

Jim McKenzie, Capt., M. C.

CORRESPONDENCE

August 9, 1944.

Arkansas Medical Society
Fort Smith, Arkansas
Gentlemen:

It was kind and thoughtful of you to write us as you did on August 7th with respect to the new advertising contract which you have received through the Cooperative Medical Advertising Bureau.

We are quite sure that the inserts which are now in process for 1945 will serve as quite an addition to The Journal and that your readers will find them interesting.

Finally, we would not consider our program complete without The Journal.

Yours very truly,
Eli Lilly and Company,
B. R. Mull, Manager,
Trade Relations and Advertising.

To the Doctors of Arkansas:

I am writing this to request your co-operation relative to the admission of patients to the State Hospital. As you recall, Act 241 of the 1943 session of the Legislature, known as the Leflar Bill, created an entirely new method of admitting patients to this institution. It provides that patients may be admitted: (1) by voluntary admission; (2) on the request of a physician or health officer; (3) on legal commitment by the chancery courts of the state.

Since this law went into effect on March 18, 1943, there has been a great improvement in the manner of receiving patients at this institution. We have seen the handcuffs disappear from these unfortunate individuals. This has been a most heartening thing.

I am sure that every physician in this state wants to do everything he can for his mental patients who have to be sent here. You can render a distinct service, not only to your patient, but to the hospital if you will observe the following simple procedures:

1. Under the provision for voluntary admission and also admission on request of a physician or health officer, please write a letter to the superintendent of the hospital setting forth the history of the case; what you have done for the patient and include in the letter a request for hospitalization in this institution. Please do not write this on one of your prescription blanks. Also, please do not fill out and send to us the interrogatories which we used under the old law.

2. In every case possible, please avoid resorting to commitment by the courts, unless it is absolutely necessary to do so. Let's spare these mentally sick patients the humiliation of having to be sent here under court commitment.

3. Encourage in every way possible the sending of patients to the hospital by relatives or friends as this adds much to the chance of the recovery of the patient. Let's do everything we can to humanize this institution.

4. Our staff is very much reduced and you can help our doctors a great deal by discouraging the sending of patients to the State Hospital during the night. Remember that our staff members are pushed to the limit of their endurance just as you doctors are out in the state. The reception of patients at night is really a problem for our depleted staff.

I sincerely hope and trust that each of you will give careful consideration to this request during this emergency.
Yours truly,
A. C. Kolb, M. D., Supt.

COMMUNIQUE

August 9, 1944.

To the Editor:

I received your letter of the 17th several days ago but did not find Dr. Martindale's address until last night. I do not know his serial number and am not sure this is all his address but feel sure this will find him. * * * I have seen him twice since I wrote last but have not seen or heard from Dr. Branch since that Sunday the three of us got together.

Things over here are about as usual. We all enjoy the good war news that we have had for the past few days.

Sincerely,
Jim McKenzie, Capt., M. C.

COMMUNIQUE

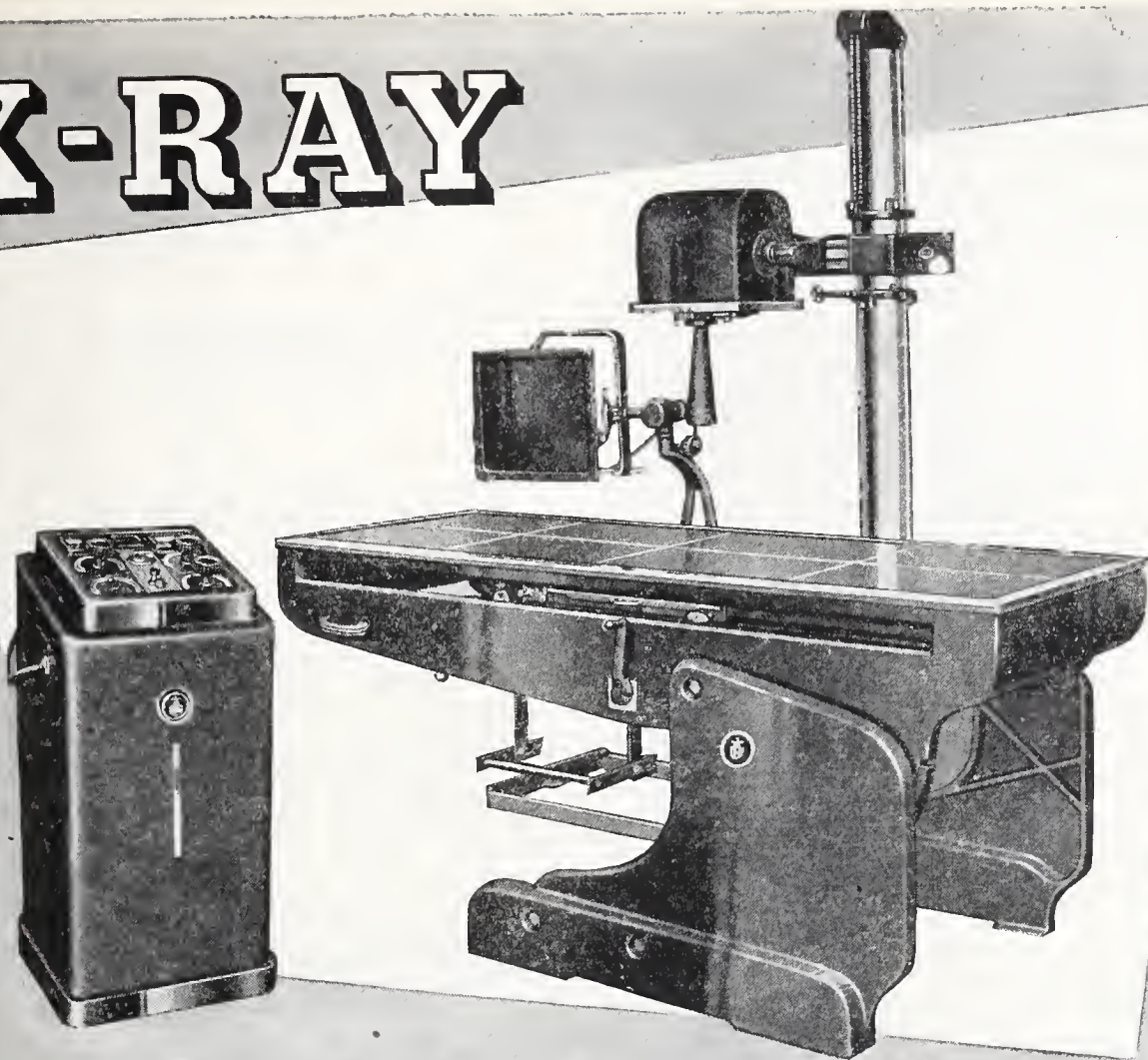
July 16, 1944.

To the Editor:

Bill Stover's "Spice of Life" came in last night's mail. This is lovely, although tormenting. Things rock along here. Am glad Paul Mahoney's communique said that you all wanted to keep "things as is." We are the greatest of opponents to regimented medical care! We are now screening showers and latrines—place is getting civilized. We have a (damaged) fluorescent view-box in our tent, a dog, and now (soon)—nurses. Best regards to all, especially Ralph Crigler, "Rear Admiral."

As ever,
John J. Monfort, Capt., M. C.

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WOMAN'S AUXILIARY PAGE

Dear Auxiliary Members:

The committee for the Erle Chambers Memorial Library Fund is asking that during September each Auxiliary member make it her particular job to publicize among club groups the important work of this fund. During the fall organization meetings when budget allotments are made, won't you speak up in behalf of this project? Every effort has been made to contact by letter all social, fraternal, and civic clubs. If you know of any which has been omitted will you please send the organization name, together with the president's name and address to Mrs. Louis K. Hundley, 444 Donaghey Building, Little Rock.

It was during the annual meeting of the Arkansas Medical Society in Fort Smith in 1940 that the Women's Auxiliary was asked to sponsor a library fund for the benefit of the two state tuberculosis sanatoria.

At that time the white sanatorium had a library pathetically inadequate, both in quantity and quality, while McRae Sanatorium for Negroes at Alexander had never had any kind of library. There was a desperate need for reading material at both institutions and the state Auxiliary was glad to assume responsibility for this most worthwhile project.

Mrs. T. Duel Brown, of Little Rock, was appointed state chairman. Clubs and civic organizations all over the state were contacted and the purpose of the project was explained. A total of \$710 was collected the first year. The Arkansas Tuberculosis Association through its secretary, Miss Erle Chambers, has been very much interested in the movement, since they

realized how important it was for these bed-ridden patients to have available sufficient reading material with which to pass many a long hour. Miss Chambers gave untiringly of her time and efforts towards this cause and after her death in January, 1941, in response to numerous requests from over the state, the name was changed to "The Erle Chambers Memorial Library Fund."

The libraries are a vital part of the rehabilitation program at both sanatoria, since many patients at both institutions are not trained to support themselves adequately, or will not be physically able to go back to their original occupations when released from the sanatorium. Suitable books have been made available for these patients who are interested in pursuing studies which will help to fit them on their return to society for work best suited to their physical capacity.

Organizations and individuals all over the state have shown their interest in the project, both in cash contributions and books. This year it is hoped that each auxiliary will increase its monetary contributions to the project, and will give considerable time to acquainting the general public with its work.

Each auxiliary is urged to contribute at least \$2, the price of one book, but no contribution is too small nor too large to add toward our goal of \$1,000 this year.

Contribution of money is preferable to books for two reasons. First, duplications are avoided, and secondly, the libraries are entitled to greatly reduced prices by purchasing in quantities.

Mrs. A. C. (Elsie) Shipp,
President.

A Collection Service Where "ALL MONEY IS PAID TO YOU"

A record of twenty-eight years service to Doctors, Clinics and Hospitals insures a kindly and understanding service to your debtors . . . Since **all money is paid to you**, you are still guardian of your accounts and all monies . . . You pay us commission only on such amounts as are paid to you . . . Won't you please write for a list of our Doctor and Clinic clients in Arkansas, and enlist our help, while the time for collections is opportune?

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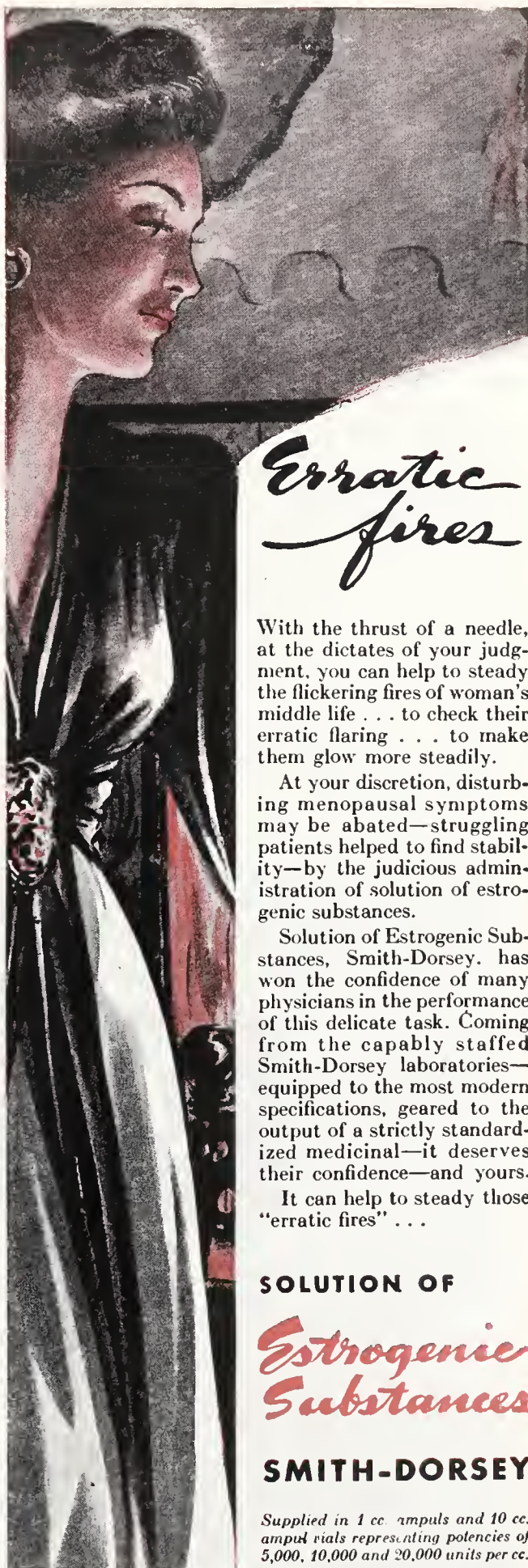
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It can help to steady those "erratic fires" . . .

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BOOK REVIEWS

Office Endocrinology. Robert B. Greenblatt, Professor of Experimental Medicine, University of Georgia School of Medicine, Augusta, Georgia. Second Edition. xii, 243 pages; 48 figures; \$4.00. Charles C. Thomas, Springfield, Ill.

Office Endocrinology is a well named and written little volume, so well written that the reader continues from chapter to chapter in that best of all moods in which to read, that of spontaneous and sustained interest. Most of the material is of very practical value while that which is not per se, becomes so in fact it furnishes a basis for understanding the procedures of the practical portions. The subject matter is largely confined to those fields of absorbing interest, endocrine gynecology and endocrine dysfunctions peculiar to the male of the species. A third section defines the physiological action of, and the indications for using the various hormone preparations in the market at the time of publication.

It is evident from the material and the manner in which it is presented that the author is a person well grounded in laboratory and animal research who has continued this interest during an extensive clinical experience. It is not intended that the book be encyclopaedic or the final word in the constantly changing endocrine field. Rather, the book is a guide for the busy medical man who is confronted all too often with endocrinopathies, many of which are not of sufficient severity to demand referral to a specialist, if one should be available.

Industrial Ophthalmology. By Hedwig S. Kuhn, M. D. Pp. 294. 114 illustrations. 2 color plates. Price \$6.50. St. Louis: C. V. Mosby Company, 1944.

The field of industrial ophthalmology is daily becoming more important. As our economy becomes more industrialized the problem of preventing ocular injuries becomes highlighted. There is one key sentence in this very worthwhile book: "The only worthwhile byproduct of industrial accidents is accident statistics." Dr. Kuhn takes statistics and many valuable text illustrations to conclusively show the value of protective devices. A chapter by Dr. Albert C. Snell, the author of the book "Medico-Legal Ophthalmology" adds to the value of this already praiseworthy volume. Epidemic keratoconjunctivitis is discussed fully and with excellent colored plates as "one of the three main causes of industrial lost time due to eye involvement." The reviewer heartily recommends this volume not only to the ophthalmologist, but to any medical or industrial library.

Synopsis of Tropical Medicine. By Sir Philip Manson-Bahr, M. D. Pp. 224. Price \$2.50. Baltimore: Williams and Wilkins Company, 1944.

In a well-condensed form this book gives ready reference to most of the diseases found in the tropics. Insects and plants which adversely affect man in these climates are also considered.

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CARDIOSPASM *

A Review of the Literature

By

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and

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The most frequent esophageal dysfunction of adult life is commonly known as "cardiospasm." This term vies with achalasia as most aptly descriptive of this functional type of esophageal obstruction at its gastric extreme with associated, or resultant, proximal esophageal dilatation. Since Thomas Willis' 1679 description of this syndrome, an ever changing terminology has been offered by authors presenting their concept of this symptom complex.

Difference in etiologic opinion has been responsible for such interesting appellations as the following, to mention only a few of the many offered:

1. "Phrenospasm" by Jackson¹ who considers the condition due to spasm of the diaphragmatic musculature, especially the right crus, creating a diaphragmatic pinch-cock. The fact that division of the right phrenic nerve does not relieve the obstruction is hardly confirmatory.

2. "Achalasia of the Cardia" is supported by Krauss², Einhorn³ and Hurst⁴ as a dysfunction of reciprocal innervation wherein the so-called cardiac sphincter fails to relax in conjunction with the contraction peristalsis of the proximal esophagus. To substantiate his title Hurst⁴ has presented cases with degenerative changes in the myenteric nerve plexus in the region of the cardiac sphincter.

3. "Mega-esophagus" was favored by Von Hacker⁵ who simulated the nerve derangement to Hirschsprung's disease and theorized a congenital origin. Such is hardly compatible with the age incidence.

4. "Simple ectasis," a term adopted by Zenker and Von Ziemissen on the supposition of

primary atony and dilatation. This reasoning is destroyed by the clinical observation that obstruction is primary and dilatation secondary (Plummer⁷).

5. "Liver Tunnel" importance has been stressed by Mosher⁸ but sufficient anatomic variance is not frequently encountered in cardiospasm and is actually offered as a simulant of cardiospasm.

Etiology:

1. Spasm
2. Vitamin B Deficiency
3. Psychogenic Factors
4. Neurogenic

It is apparent that little can be claimed for the adoption of any of the titles other than achalasia for as yet the etiologic background of this entity remains problematic. That a sphincter exists has been a debatable contention since an early date (Baillie 1793) with Hurst amply proving at least a physiological sphincter roentgenologically demonstrable. It is assumed by him and others that failure of the sphincter to relax produces the syndrome of achalasia; if the cardia fails to relax we assume it capable of contraction! Kinking of the esophagus as with kyphosis as proffered by Moore and Vinson⁹, and diaphragmatic ptosis sponsored by Mosher,¹⁰ are merely interesting coincidents. Likewise incidents of intra and extra-esophageal fibrosis, anomalous length, pressure of lung tips and hypertrophied oblique muscle of the stomach are hardly conclusive. The field, etiologically, ranges wide with hypotheses which, of course, include allergy. Actual organic esophageal disease is occasionally present, although debatable whether cause or effect, such as peptic ulcer of the esophagus, esophagitis and diverticulum.

Neurogenic dysfunction including vagal lesions, sympathetic disturbance and myenteric plexus degeneration due to various causes and also the psychogenic states have gathered more support in recent years, as is the popular trend with the illusively impressive term psychosomatic; especially when pathological observations render other possibilities incompatible. Even here there

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are many debatable angles with conflicting experimental studies and unsatisfactory clinical observations.

1. Spasm is favored with supportive findings by Knight¹¹ that in cats, esophageal sphincteric contraction follows sympathetic stimulation while relaxation is induced by irritating the vagus. By bilateral vagus section he produced cardiospasm; when accompanied by celiac sympathectomy the syndrome did not develop. Unfortunately when applied to human subjects (Mitchell¹²) sympathectomy, even though to an extent impractical, is not therapeutically successful.

2. Nutritional Deficiency States: Etzel¹³ in an instructive and somewhat conclusive survey is the principal supporter of this theory which has enjoyed confirmation.¹⁴ A degeneration of the intramural nervous system is theorized as an anatomic basis for cardiospasm which etiologically is attributed to Vitamin B deficiency. Is this causative, or does the deficiency result from cardiospasm? The pathological study of Lendrum²² revealing the myenteric plexus degeneration confirms the work of Hurst and Rake and supports Etzel's hypothesis. We do not see many instances in this country so specifically related to Etzel's description.

3. Psychogenic factors enjoy a distinctive position; it is difficult to deny them. Psychogenic influences are often precipitant with emotional or nervous^{15 16 17 18} reactions encountering a susceptible autonomic nervous system. Plummer⁷ and Vinson³⁰ each authoritatively state the entity is not a neurosis.

4. Neurogenic, are those instances resulting reflexly from gastric, intestinal and biliary diseases, e.g., reflex from peptic ulcer, appendicitis and cholecystitis.

It is therefore conclusive that no theory has been proven and the exact mechanism by which cardiospasm develops remains unknown. As with peptic ulcer it is therefore assumed that in a limited number of instances the cause is definite but in the majority of cases a combination of factors contribute to the occurrence in a neurogenically predisposed individual.

Symptomatology:

1. Dysphagia
2. Pain
3. Esophageal Decompensation
4. Bronchopulmonary Manifestations

Dysphagia is cardinal. It varies in severity from consciousness of food passage to complete esophageal obstruction. After an abrupt onset it is characteristically intermittent, often precip-

itated by psychogenic insult, cold liquids or irritants; the subsequent course is progressive to persistency.

Early, food seems to stick in the cardiac esophagus; bread and meats are the first offenders. Choking while eating is frequent. In advanced cases the food accumulates in the esophagus and the patient resorts either to copious liquids acting as a hydrostatic dilator or to the employment of forcefully increased intrathoracic pressure. Complete obstruction is not unusual in neglected cases.

Pain is essential to the picture. Again the variation is to extremes. Retrosternal pressure or discomfort, a sensation of fullness, perhaps a burning, are the minimal complaints. Severe colic, chest compression or intense sharp radiating anginoid pain may occur. The radiation is bizarre, perhaps into the shoulders, neck, ear, ramus of the mandible and left arm. The distribution of pain is not easily understandable, a reproduction of Chester Jones'¹⁹ charts illustrate the possibilities.

In our experience, reproduction of the patient's pain by the act of stretching the spastic cardia with the pneumatic mercury²⁰ dilator reveals the specificity of the cause and effect; this is merely confirmatory of the findings of Jones¹⁹ and Morrison and Swalm.²¹

There is apparently "a final common pathway over which various perceptions are referred although the original stimulus may arise in widely separated structures."¹⁹

A vago-vagal reflex explanation is unsatisfactory and as far as present research carries the mechanism of pain reference is not thoroughly understood.

Jones' work with individuals on whom thoracic ganglionectomies had been performed, in unilateral cordotomy and with novocaine blocks, lead to the finding that the distribution of esophageal pain was essentially unaltered, thus rendering other explanatory pathways necessary. Sensory vagal pathways, sensory esophageal ascending fibers seeking a cervical level, all seem possible. The simulation of esophageal, cardiac and biliary pain is often remarkable; further, to complicate one's decision is the fact that nitrites relieve the pain originating in spasm for each site.

Esophageal Decompensation is, in our opinion, a part of the picture. The compensated esophagus is only slightly dilated and compensated the increased intra-esophageal pressure by muscle and elastic hypertrophy. Decompensated, the esophagus dilates to become elongated with

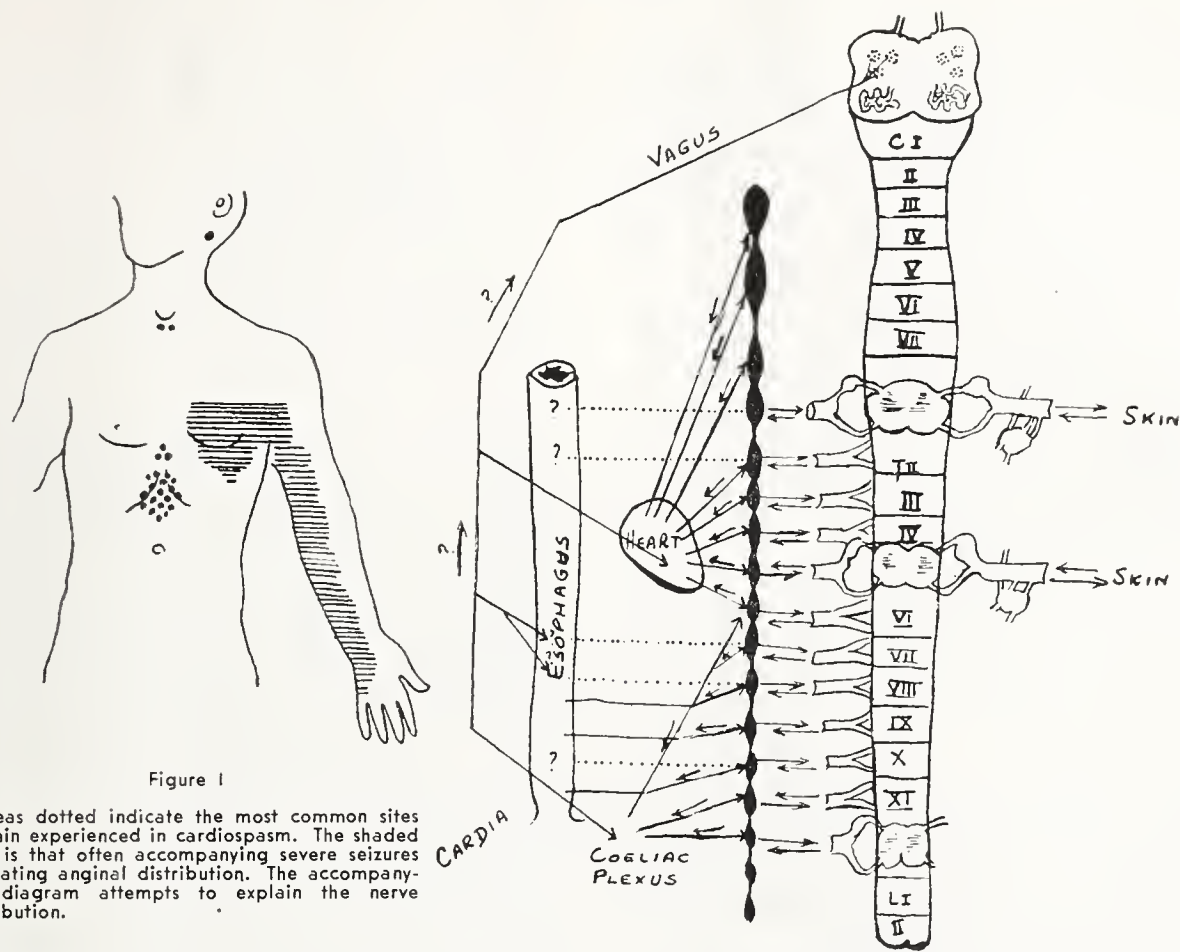


Figure 1

Areas dotted indicate the most common sites of pain experienced in cardiospasm. The shaded area is that often accompanying severe seizures simulating anginal distribution. The accompanying diagram attempts to explain the nerve distribution.

resultant kinking and muscular thinning; there is not a stage of such advanced disease with esophageal wall hypertrophy.

With this advanced pathology there is esophageal retention of food producing postprandial substernal fullness with a sensation of weight in the chest and actual quantitative (esophageal) dyspepsia. Spontaneous and induced regurgitation of alkaline material is common, reflux into the buccal cavity at night is a typical occurrence. Esophagitis develops with substernal burning, as the disease progresses these symptoms advance in severity. Inanition and vitamin depletion become an eventuality.

Bronchopulmonary Manifestations result from the pressure of a decompensated, filled esophagus or from regurgitation of the content into the tracheo-bronchial tree. Acute and chronic tracheobronchitis, advanced bronchiectasis, pulmonary fibrosis, aspiration pneumonitis, pulmonary abscesses and plural effusion have been reported. The associated symptoms are obviously those of complication and are not specific of cardiospasm.

Diagnosis:

1. Roentgenologic Study
2. Esophagoscopy.

While a characteristic clinical picture can

often be developed and while such factors as "deglutination time" are of interest it is only by radiography or endoscopy that a satisfactory diagnosis is possible. There are no physical findings of significance. The claim of bloodless bougienage is worthless.

Confirmatory roentgenograms show a blunt or tapering smooth occlusion of the hiatus esophagus with proximal esophageal dilatation and angulation. The extremes of dilatation and angulation are practically pathognomonic.

Esophagoscopy rules out organic disease and complication and thereby aids the diagnosis. In the decompensated cases the white, pasty, macerated mucosa and normally contracted hiatus esophagus which, when found permits the large esophagoscope to pass into the stomach, are characteristics.²⁸

Complications:

1. Chronic Pulmonary Disease
2. Diverticulum of Esophagus
3. Esophagitis
4. Peptic Ulcer of Esophagus
5. Carcinoma of Esophagus
6. Spontaneous Pneumothorax
7. Vitamin Deficiency espc. Pellagra
8. Epithelioma of Esophagus

Cardiospasm may be associated with or the cause of chronic pulmonary ^{23 24 25 26} disease. The coincidental occurrence seems too frequent to be merely an association and the reports of bronchitis and bronchial asthma, aspiration pneumonitis, lung abscess, bronchoectasis and pulmonary fibrosis favor cardiospasm being causative by producing reflux into the bronchial tree.

Diverticulum of the pulsion variety may conceivably result from cardiospasm due to increased intraesophageal pressure and muscular weakness.

Esophagitis is easily understandable. The esophageal mucosa is not designed for retained putrifying food particles and resulting inflammatory changes are to be expected.

Ulceration may be a primary condition and result in scarring or irritation to cause an impure cardiospasm or it may result from the esophagitis and circulatory disturbance resulting from a true cardiospasm.

Carcinoma of the esophagus without cardiospasm is relatively frequent and seldom seems to be the result of the chronic irritation excited by cardiospasm. Kornblum and Fisher ²⁹ reported three instances of carcinoma developing in the dilated esophagus of cardiospasm.

Vinson ³⁰ reported spontaneous pneumothorax occurring in a patient who was voluntarily trying to force food through this spastic cardia.

Marsh ³¹ published an incident of pellagra due to cardiospasm. It is remarkable that such is not more frequent than more marked avitaminotic states associated with the severe inanition of advanced neglected cardiospasm do not come into existence. This possibly explained by the associated enforced lowered metabolism. Etzel and others would have us put the "cart before the horse."

Brock ³² recently reviewed the subject and added two case reports of epithelioma developing in patients known to have cardiospasm. One individual had a therapeutic record for cardiospasm of twelve years.

Differential Diagnosis:

1. Fibrotic Benign Stricture
2. Carcinoma and Other Malignancies
3. Benign Tumors
4. Plummer-Vinson Syndrome
5. Hysterical Dysphagia
6. Mediastinal Tumors
7. Diffuse Spasm Lower Half Esophagus
8. Muscular Hypertrophy Cardiac Sphincter
9. Angina Pectoris
10. Peptic Ulcer of the Esophagus
11. Hiatal and Para-esophageal Hernia

12. Diverticulum
13. Reflex from other Gastrointestinal Diseases
 - (a) Peptic Ulcer
 - (b) Pylorospasm
 - (c) Appendicitis
 - (d) Biliary Disease
14. Cardio-aortic Disease
15. Tuberculous Periesophageal Abscess
16. Esophageal Varices
17. Neurological Conditions
18. Foreign Body

In differential diagnosis the above entities due to their obstructive esophageal nature or to simulation in manifestations must be considered.

Fibrotic benign stricture in over 80 per cent of cases has a history of ingestion of caustics, healed ulcer or esophagitis. Congenital etiology exists and Vinson ³³ declares the cause cannot be determined in 20 per cent of cases. Deep X-ray therapy to the thoracic cage produced an instance under our observation. X-ray reveals the nature of the stricture, however, and in most instances it is higher than the cardia.

Carcinoma should not be differentiated by history as suggested by Freeman. ³⁴ The roentgenologist will usually designate the lesion malignant from its irregularity. The marked proximal dilatation of cardiospasm is not a part of the picture of carcinoma unless the malignancy develops secondary. Esophagoscopy and biopsy are essential to a conclusive diagnosis. Sarcoma and other malignancies may be mentioned but are extremely rare.

Benign tumors such as polypi, lipomas, myomas and fibromas are relatively rare. The roentgenologist may suggest their benignancy but confirmatory esophagoscopy is necessary.

The Paterson ³⁵ or Plummer-Vinson ³⁰ syndrome of hypochromic microcytic anemia, atrophic glossitis, and achlohydria occurring most commonly in menopausal women, is characteristic. Negative esophageal radiography proves the differentiation. Paterson described this syndrome prior to Plummer and Vinson. Hysteria tends to disappear rather than progress. Symptoms are at a higher esophageal level. X-ray studies are normal.

Mediastinal tumors and aortic aneurysms give other manifestations, ^{17 26} the obstruction is not at the diaphragmatic level, roentgen study and esophagoscopy reveal the extraluminal site.

Diffuse spasm of the lower half of the esophagus occurs characteristically in relation to the temperamental status of the patient. Roentgenoscopy reveals diffuse irregular spasm, multiple

apastic segments and diffuse narrowing of the distal half of the esophagus.

Muscular hypertrophy of the cardiac sphincter, analogous to congenital hypertrophic pyloric stenosis, is rare and has only been diagnosed surgically or pathologically. It may be suspected from a cone-shaped smooth, symmetrical obstruction without dilatation.

Edeiken³⁶ has emphasized instances simulating angina. The differentiation is by proper cardiovascular evaluation remembering angina might accompany cardiospasm.

Esophageal peptic ulceration has an ulcer syndrome but roentgen and esophagoscopy study are indicated for the two may be associated as cause and effect or vice versa.

Hiatal and para-esophageal hernia, and esophageal diverticulum are roentgen diagnoses.

Spastic esophageal states precipitated reflexly from disease elsewhere in the gastrointestinal tract require adequate evaluation of the manifestations and roentgen findings.

Cardio-aortic disease, of course, demands evaluation from a cardiac viewpoint with awareness of the possibility. When cardio-aortic disease is so advanced as to cause dysphagia a differential diagnosis should not be difficult.

Clerf³⁷ added the unusual with an instance of tuberculous periesophageal abscess producing extreme dysphagia. This diagnosis was endoscopic.

Esophageal varices sufficiently severe to simulate cardiospasm show hepatomegaly and positive roentgen delineation.

Such neurological lesions as myasthenia gravis, progressive muscular atrophy, amyotrophic lateral sclerosis, pseudo-bulbar palsy and arteriosclerotic cerebral changes often cause dysphagia. Ability, clinically, renders the differential diagnosis simple.

Occasionally a foreign body may produce dysphagia. The history is usually conclusive. Roentgen study will reveal the type of obstruction. It must be remembered that esophageal disease may have permitted the body to lodge in the esophagus.

Pathogenesis:

1. Fibrosis of the terminal esophagus (Mosher)
2. Loss or absence of ganglion cells from myenteric plexus (Lendrum)
3. Chronic inflammatory changes (MacCready)

Pathological studies on cardiospasm are not voluminous nor are they in agreement. Mosher^{38 39} supports a fibrosis of the terminal portion of the esophagus resulting from an inflammatory

process. In a study of 30 consecutive cases he demonstrated a crural crease in the esophagus, this he believes is due to fibrosis of the connective tissue in the crural ring associated with fibrosis of surrounding structures.

Lendrum²² in a study of 13 cases denies Mosher's claims. He uniformly found a "striking loss or complete absence" of ganglion cells from the myenteric plexus. His findings were compatible with Hurst's theory of achalasia. Hurst and Rake, in eleven cases pathologically studied, found inflammatory or degenerative changes in all of the eleven specimens; one of these was in an early case with hypertrophy but no dilatation.

In an attempt to confirm Mosher's contention MacCready⁴⁰ expounds the chronic inflammatory changes in two cases he studied.

In agreement with our way of thinking Turner⁴¹ opines that cardiospasm is not usually associated with gross structural change in the wall of the esophagus but that such occur as an effect of cardiospasm.

In the development some neuromuscular defect probably is etiologic, then with this functional obstructive mechanism the circular muscular wall of the esophagus hypertrophies with increased thickening and slight dilatation. Stasis leads to inflammatory changes in the mucous membrane which, extending deeper, causes degenerative changes in the esophageal wall involving the myenteric plexus which, under long continued pressure, is overcome with resultant dilation and necessarily elongation with tendency to bend and kink. In such an esophagus reparative process is by fibrosis, and therefore, in some instances produces organic stenosis; but why should this be so selective of the cardia? Secondary esophagitis, erosion and ulceration are pathological results.

The pathogenesis is therefore debatable, the pathological changes found at autopsies may well be resultant and cannot be proven otherwise than Lendrum's finding that the loss of ganglion cells is equally great in the undilated neck at the cardia as in the dilated sac.

Treatment:

- I. Conservative or medical Management
 - a. Diet
 - b. Antispasmodics
 - c. Aminophyllin
 - d. Nitrites
 - e. Thiamin Chloride
 - f. Prostigmine
 - g. Psychotherapy
 - h. Endocrine
 - i. Allergy Control

- j. Hyperpyrexia and Diathermy
- k. Spinal Anesthesia
- l. Bougienage

II. Operative Management

- a. Gastrostomy and Dilatation
- b. Plastic Procedures at Cardia
- c. Sympathectomy

Medical Management:

General measures to improve the mental and physical well-being of the patient are essential but not specific. Dietotherapy varies with the degree of involvement from high caloric fluids to a full bland diet, no exact dietary outline is practical. We deny that statement that drugs are of no use. We must admit gradations of severity. There are mild cases which after single bougienage, may be controlled by an occasional antispasmodic. Conversely severe instances may likewise gain temporary and emergency relief during periods between dilatations. We have found nitroglycerine and amylnitrite, advocated by Ritva and McDonald,⁴² most effective in emergency relief and for pre-dilatation relaxation in difficult cases. Aminophyllin gives excellent results without the unpleasant side reactions of nitrites. Atropine, papaverine hydrochloride, stramonium and synthetics: Octin, Trasentin, Syntropan and Pavatrine, have relaxing qualifications in selected instances but in our experience are only effective in mild cases and in association with bougienage in the severe cases. Morphine relaxes the distal esophagus well but for obvious reasons is avoided.

Thiamin, regarded specific by some,⁴³ may be used to supplement other measures. Regardless of the validity of Etzel's contention, a vitamin deficiency, whether primary or secondary being unproven, is frequently apparent.

Meyer and Necheles⁴⁴ in dog experimentation and a limited clinical application sponsor the use of prostigmine orally and parenterally.

Psychotherapy has limited but definite application. Control of nervousness and rest often bring startling improvement. Every good physician adds a degree of psychiatry to every therapeusis he employs.

Theorizing a parathyroid disturbance etiologic in an instance of a calcium deficient cardiospastic relieved by parathyroid extract and calcium, Levin⁴⁵ adds this therapeutic aid in selected cases.

Withers,⁴⁶ in substantiating an allergic instance, controlled symptoms produced by ingestion of allergens: chocolate, peanuts and string beans, with adrenalin.

Hyperpyrexia,⁴⁹ local diathermy and spinal anesthesia⁵⁰ have been advocated but deserve only mention. Ptosis belts may possibly aid in visceroptotics.¹⁰

Bougienage of one variety or another has been practiced for more than fifty years in relieving dysphagia and promoting better drainage of the esophagus due to cardiospasm.

In a review of dilators, mention must be given to semi-stiff fiber bougies and mechanical dilators inserted through the esophagoscope. Their use necessarily involves a semioperative procedure, they are more applicable in cases where scarring or fibrous stricturing exists. Sippy's graduated olives, and those of others, in various sizes and shapes attached to a fiber and guided by a swallowed thread, are introduced fearlessly by persistent adherents. They are probably safest in expert hands. We have seen under the fluoroscope an apparently taut cord loosen, the bougie fail to engage the cardia and pass blindly into a dilated esophageal pouch. Because of this as well as of other obvious limitations, they must be reserved for the expert endoscopist.

Hurst⁵¹ introduced his mercury filled bougies in 1913. They are rubber tubes varying in diameter (from 21 to 40 English), 31 inches long and each containing the same quantity of mercury (21 ounces). These are carried and guided through the esophagus by their weight, opening a passageway by their size.

These dilators, in our experience, are the easiest passed; they cause less discomfort and are unquestionably the safest instruments available in properly indicated cases. Successively larger tubes are passed at a single sitting, and in most cases the largest one meets with only slightly more resistance than the smallest.

Additional factors in the use of these bougies include the following: (1) In the instance of narrowing sites, in addition to that at the cardia, all are dilated to the same extent by the one passage. (2) Patients have been taught to use the bougies in selected instances. (3) No fatality has been recorded from the use of this procedure. (4) It is obvious that these bougies have limitations and are best employed when the cardiac opening remains dependent and the existing pathologic condition has not brought about a great sacculation at a level below the hiatus although we have employed them quite successfully in severe cases. (5) The large size, No. 40, often proves annoying to patients because of the bulk in the pharynx.

The history of the bag divulsion dates back to

J. C. Russel's work of 1898. In 1906 at the Mayo Clinic, Plummer modified Russel's instrument and introduced into prominence the rubber-covered silk balloon using hydrostatic pressure. Moersch and Vinson, with their excellent work and statistic accumulation, have sustained their preceptor's teachings.

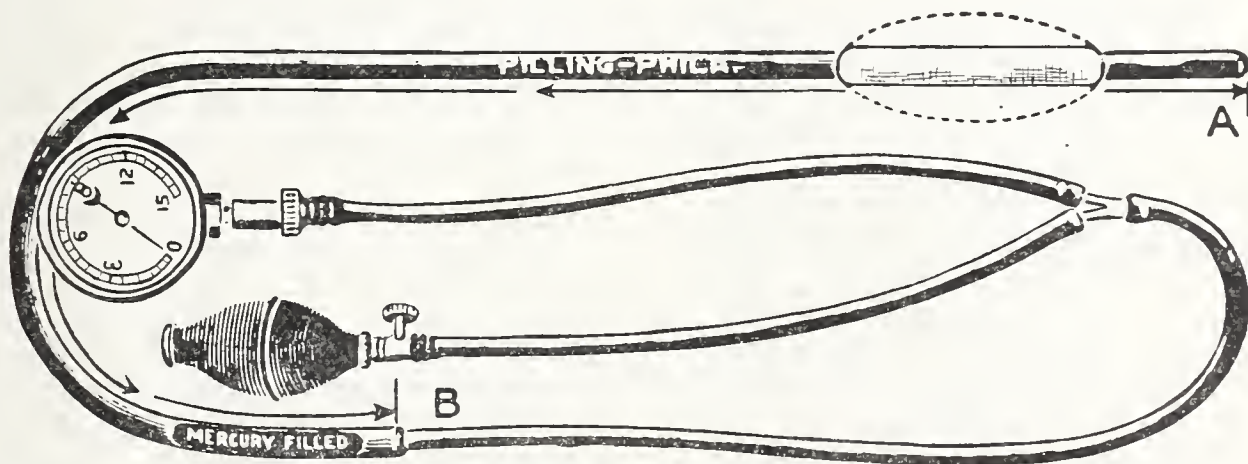
The instrument is a rubber tube supported by a whalebone staff tipped with an olive just behind which is a rubber-covered silk balloon which is dilated by hydrostatic pressure regulated by special adapters. All dilations are carried out over a previously swallowed silk thread (five yards) held taut, which is thought to eliminate all danger of perforation. It requires a source of running water and is not portable and for this reason is not as practical as could be wished. Failure to place the dilator, unsatisfactory results due to improper technic, considerable pain and a mortality percentage are admitted; however,

it has a definite advantage in that divulsion is achieved by its use.

In 1929 Frank Smithies designed the pneumatic dilator modification of Plummer's apparatus in an effort to remedy proved limitation of the latter divulsor. Smithies' dilator, being portable, requiring no special water supply, being devoid of whalebone staff but having a metal shaft with a safety control, and being of inexpensive construction, was a notable achievement. It rendered fluoroscopic control of divulsion dilation practical. Its only essential distinction from the Plummer dilator, however, is that it is pneumatic.

Since September, 1938, we have used a mercury pneumatic dilator.²⁰ This new dilator and divulsor combined the principles of Hurst, Plummer, and Smithies and achieves a position of maximal efficiency and safety.

Drs. Donovan C. Browne and Gordon McHardy, New Orleans



It is a No. 2 Hurst mercury tube; on the distal end, 7.5 cm. from the tip, has been incorporated a rubber-covered silk bag 11 cm. in length to which a small catheter runs through the mercury filled tube. By this means distention, under the control of a manometer, may be effected.

The distinct advantages of this instrument are that: (1) A swallowed guiding thread is not required; it is easily passed, being the size of the small Hurst dilator. It is carried through by virtue of its contained 21 ounces of mercury, which is sufficient to force the closed sphincter and which is in itself a guide but which is not sufficiently forceful to traumatize or perforate the esophagus. (2) This type dilator is most easily passed with less discomfort than any other type and does not show any tendency to coil in a dilated pre-diaphragmatic dilation, as might be suggested by some. (3) Only a single instru-

mentation is required, as contrasted to the passing of an olive prior to the use of a Plummer dilator and the use of graduated Hurst bougies. (4) It offers controlled pneumatic divulsion, which is more practical and safer than hydrostatic dilation, and this in combination with the bougie qualifications of the Hurst dilator. (5) It is applicable to X-ray examination. (C. L. Jackson has added barium lines to facilitate fluoroscopic visualization.)

Surgical Management:

It is not entirely within the realms of internal medicine to freely discuss operative procedures and we will therefore merely dwell upon the subject sufficient to complete this survey of cardiospasm.

In 1933 Moersch,²² reviewing 805 instances of cardiospasm managed, conservatively reported 71 per cent responding satisfactory to medica-

tion and bougienage. In his group of failure there were nine deaths from esophageal splitting during divulsion and two from starvation. The ten-year interval has brought increased diagnostic acumen thereby bringing more earlier cases with minimal esophageal changes. Improved technique, safer and more satisfactory instrumentation has increased our percentage of medical successes. Gray and Skinner⁵³ reported that in over 1,200 cases of cardiospasm seen at the Mayo Clinic operative management was resorted to in only seven instances.

However, there does exist then this small group of cases in which a tremendously elongated and dilated esophagus renders peroral dilatation either impractical or impossible.

To simplify the presentation we have modified the classification of Ochsner and DeBakey.

- I. Operations directed at the dilated esophagus:
 - a. Longitudinal excision of strips of esophagus with closure (Jaffe⁵⁴-Reisinger⁵⁵)
 - b. Esophagoplication, suturing together longitudinal folds (Meyer⁵⁶)
 - c. Esophageal shortening by intussusception in cervical region (Freeman⁵⁷)
 - d. Esophagostomia thoracica (Zaaijer⁵⁸)
- II. Operations directed at the diaphragm:
 - a. Phenotomy, division of diaphragmatic crura (Bassler⁵⁹)
 - b. Transposition of esophagus by drawing it down through an enlarged hiatus (Hacker⁶⁰)
- III. Operations directed at the cardia:
 - a. Dilatation: (1) Transgastric, without gastrostomy (Rotgans⁶¹); (2) Retrograde, through gastrostomy (Von Mikulicz⁶²)
 - b. Cardiectomy combined with esophagogastronomy (Pribam⁶³)
 - c. Plastic: (1) Cardiomyotomy, analogous to Ramstedt pyloroplasty (Heller⁶⁴); (2) Cardioplasty, analogous to Heineke-Mikulicz pyloroplasty (Wendel⁶⁵); (3) Esophagogastronomy, analogous to Finney pyloroplasty (Heyrovsky⁶⁶-Womack⁶⁷) (Eggers,⁶⁹ Churchill⁷⁰)
- IV. Operations directed at the nerve supply:
 - a. Vagotomy: (Meyer,⁵⁶ Sauerbruch,⁷¹ Rieder,⁷² Jirasek⁷³)
 - b. Sympathectomy: (1) Decortication of Auerbach's plexus (Recalde⁷⁴);

- (2) Excision left gastric artery (blood supply to celiac plexus) (Knight⁷⁵); (3) Bilateral Cervicothoracic Sympathetic ganglionectomy (Craig, Moersch & Vinson⁷⁶)

Obviously the first two groupings have fallen into a historically interesting category and are included with their references for those who may be interested in delving into the past. Their application to the effect rather than the cause was irrational and they proved valueless.

The third section includes a discard, cardiectomy, which is impractical in that it carries too great a mortality without counter-balancing advantages. Simple gastrostomy is often life-saving in preventing starvation and is still a satisfactory means of retrograde dilatation, manual or preferably with Tucker dilators, in instances not manageable peroral. The plastic procedures hold the most favorable position and of these a transabdominal esophagogastronomy using the technique outlined by Frey to avoid a spur is preferred. By this method, Wachs reviewing 99 collected cases, claimed 93 successful instances, one poor result and five mortalities. Uniformly the functional result following operation is better than the roentgenologic studies would indicate.^{69 78 79}

Neurosurgery has passed from a phase of enthusiasm to the realm of reality and found inadequate. Vagotomy has only historical significance. Recalde's⁷⁴ early work has been discounted. Knight's⁷⁵ outstanding experimental work added knowledge to the issue but resection of the left gastric artery and the associated sympathetic fibers has given neither impressive nor permanent results. Bilateral resection of the cervicothoracic sympathetic ganglia and trunk suggested by Craig, Moersch and Vinson does not promise permanency and its benefits are nullified by the associated Horner's Syndrome.

Bird⁸⁰ has summarized the sympathectomy issue in his conclusion that it seems unlikely that any operation of reasonable magnitude will effectively remove the sympathetic supply to the cardia. Furthermore, mechanical factors prominent in advanced cases are not rectified by sympathetic surgery.

Summary:

- I. The concept of a physiological esophageal sphincter at the cardia is acceptable and may theoretically produce "Cardiospasm" or "Achalasia," two seemingly contradictory terms used generally to describe the same disease.

2. With Myenteric ganglion degeneration pathologically proven in this entity Etzel's theory of Vitamin B deficiency is supported.

3. This paper is actually a review on an interesting subject, one of the few entities existing about which so much indefiniteness exists combined with extraordinarily effective therapeutic measures which have prevented extensive pathological studies.

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OKLAHOMA CITY CLINICAL SOCIETY

The annual conference of the Oklahoma City Clinical Society will be held October 23, 24, 25, and 26, at the Biltmore Hotel, Oklahoma City, Oklahoma.

Physicians of the Southwest will again be offered an intensive series of clinics and lectures covering the most important fields of medicine, surgery, and the specialties.

The President of the American Medical Association, Dr. Herman L. Kretschmer, and sixteen guest lecturers who are recognized leaders in their respective fields will be present for the four-day session.

This meeting is dedicated to the needs of the general practitioners and every effort has been made to keep the lecture material as practical and non-technical as possible. It is believed that these practical clinical lectures will be of inestimable value to physicians who must meet greater demands for practical therapy.

The officers of the Society have labored long and faithfully in preparing the program which, it is believed, will compare favorably with the usual high standard maintained by this conference since its inception.

Surely all Southwestern doctors will eagerly anticipate the opportunity to hear each member of the carefully selected faculty.

Oklahoma City is easily accessible at a minimum expenditure of time, from all points in the Southwest, by rail, bus, and plane service, as well as by a network of excellent highways. The convenient location, coupled with the necessity for post-graduate teaching courses, makes this meeting the logical one to attend.

The usual scope and plan of the meetings will be unaltered this year. The general assemblies, dinner meetings and round table luncheons will be held as usual.

Mark these four days in red on your calendar—October 23, 24, 25, and 26, and plan, NOW, to attend this meeting.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

TUBERCULOSIS presents itself in varying aspects and it is often difficult to recognize it even after careful study. The fact that the death rate from tuberculosis among older men has remained high has not been generally recognized nor its importance in the practice of medicine accepted and the fact applied.

CASE REPORT FROM THE MASSACHUSETTS GENERAL HOSPITAL

Presentation

A 79-year-old retired factory manager entered the hospital because of persistent cough. The patient had been in excellent health until six months previously when without upper respiratory infection he developed a paroxysmal cough producing a small amount of nonodorous, greenish sputum. Six weeks after admission the amount of sputum increased to several tablespoons daily. He developed a "smoky feeling" under the sternum at the level of the sixth rib, without definite pain. He has had no hemoptysis, chills, fever or weight loss. A chest X-ray film showed slight enlargement of the heart downward and to the left. The lower part of the right lung field was less radiant than normal. In the lateral view the outline of the middle lobe was easily seen, and its position corresponded to the area of fullness in the right lower chest. The interlobar septa were moderately thickened. The lung fields were otherwise clear.

Six years earlier after a life of extreme activity he had been advised to slow down. Two or three years later he noted shortness of breath upon climbing two flights of stairs.

Physical examination showed a well-developed, well-nourished man, distressed by frequent cough. The trachea was in the mid-line. There was dullness posteriorly over the right clavicle. Breath sounds were increased and well transmitted. Many moist inspiratory and expiratory rales were heard over the right middle and upper lung fields. There was a loud moist wheeze over the whole right lower chest. The heart was slightly enlarged; the sounds were regular but faint. Examination was otherwise negative. The blood pressure was 158 systolic, 88 diastolic; the temperature was 99.4 F., the pulse 85, and the respirations 24.

Blood examination showed a hemoglobin of 14.9 gm., a white-cell count of 6,800 with 64 per cent neutrophils. The urine was normal. A blood Hinton was negative. A chest X-ray, taken two weeks after the earlier one, revealed some increase in the size and density of the lesion on right. There was no respiratory movement of the right half of the diaphragm. The outline of the diaphragm was irregular, and the right costophrenic sinus was shallow. The pleura was somewhat thickened along the axillary border. A bronchoscopy was done on the third hospital day.

Differential Diagnosis

Dr. Helen Pittman: May we see the X-ray films?

Dr. Milford Schulz: The right lobe does not seem to me to be particularly decreased in size. There is hazy increased density overlying the right lower chest.

Dr. Pittman: What about the pleural thickening?

Dr. Schulz: There is a little on the right and I wonder if the increase in density on the right side as compared with the left might not all be due to the thickened pleura.

Dr. Pittman: What about the position of the diaphragm on the left?

Dr. Schulz: It is elevated. A true paresis of the left half of the diaphragm, which would have been noticed fluoroscopically, was not observed.

Dr. Pittman: There was true paresis on the right?

Dr. Schulz: That must be accepted as the fluoroscopist's observation.

Dr. Pittman: These films do not throw much light on the subject and I am rather disappointed.

This 79-year-old man was in excellent health until the age of 73 when he was advised to "take

it easy." He had shortness of breath, not unusual for one that old.

His illness began six months previously, when without any prodromal or respiratory symptoms, he suddenly began to have paroxysmal cough and raised small amounts of sputum; this continued for four months. Then, for no apparent reason, the patient developed a "smoky" feeling—whatever that means—under the sternum at the level of the sixth rib. He had no pain, chills, fever or weight loss and did not spit blood. The only clue is that he had productive cough.

Physical examination showed dullness posteriorly on the right, over the right clavicle. "Breath sounds were increased and well transmitted." They usually are in that region of the chest. The loud moist wheeze over the right lower chest is the first thing that gives a localizing clue; the unilateral wheeze I interpret as a definite indication of partial obstruction of one bronchus on the right side, the middle or lower lobe, I cannot be sure which. He had slight fever, which seems noncontributory. He had no anemia, and no leucocytosis and the white count was normal, with a low percentage of neutrophils.

We have here a man with a cough who had nothing to go with a cough and no evidence of infection beyond a temperature of 99.4 F. At no time had he bleeding or pain or anything that should lead one to suspect carcinoma. Of all things that should make one suspect carcinoma, bleeding is the most important. The absence is important but not necessarily diagnostic.

Then we come to the next positive finding—the area of increased density in the right lower chest. The only other definite positive finding is that there was no respiratory movement of the right half of the diaphragm. Why I do not know. We have nothing to suggest that there was a phrenic involvement on that side. It is hard to think of an aortic aneurysm involving the phrenic nerve with as little to go on as this.

The immobility of the diaphragm is an important finding but there is not enough evidence to say whether or not it is due to acute pleurisy.

There remains the area in the right lower chest, which is perhaps secondary to the paralysis of the diaphragm. I rather doubt it because he is producing large amounts of sputum. A partial obstruction of the bronchus causing the wheeze may be assumed. This is unrelated to the diaphragm unless we assume carcinoma for which there is no evidence.

A bronchial adenoma must be considered but there is no evidence for it nor for a nonopaque foreign body.

Tuberculosis always has to be thought of, but again there is not much to go on. It is an unusual site for tuberculosis, although that does not rule it out. In a 79-year-old man I should certainly expect more evidence of old tuberculosis elsewhere in the chest than we have in this X-ray film. There is no evidence of old pleural infection to make one think that he could have had empyema and a bronchial fistula.

There remains, therefore, a series of entirely unsatisfactory explanations for this man's condition. Because of the physical signs and wheeze on the right side I am going to cling to a partial obstruction of the bronchus. Because I have no satisfactory evidence for carcinoma or tuberculosis, I am going to call it adenoma, but with little faith.

Dr. Edward B. Benedict: We did a bronchoscopy with a preliminary diagnosis of carcinoma; the most likely diagnosis at this age was probably carcinoma. Bronchoscopy showed widening and partial fixation of the carina, and a nodular outcropping in the right-stem bronchus causing partial obstruction of the right middle and lower lobes.

Clinical Diagnosis: Carcinoma of the lung.

Dr. Pittman's Diagnosis: Bronchial adenoma.

Anatomical Diagnosis: Tuberculosis of the bronchus.

Dr. Benjamin Castleman: The material received showed a granulomatous process, with one suggestive tubercle. The amount of material was insufficient for a positive diagnosis of tuberculosis. It looked suspicious of tuberculosis, however, and this was confirmed by examination of the sputum, which contained numerous tubercle bacilli. The patient therefore had tuberculosis stenosis of the bronchus, probably with involvement of the mediastinal lymph nodes.

Case Records of the Massachusetts General Hospital, The New England Journal of Medicine, April 13, 1944.

COMMUNIQUE

August 18, 1944

To the Editor:

I am now located in * * * in a hospital evacuating patients to the States by air. This is a most interesting work and one gets to see a great variety of cases.

So far I haven't seen any of the men from Arkansas and that may be due to the fact that I haven't been here long enough.

Best regards,

H. H. Holt, Capt., M. C.

THE JOURNAL

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EDITORIALS

THE PRIVATE PRACTITIONER AND
PUBLIC HEALTH

FOUNT RICHARDSON, M. D.
Fayetteville
(Major, M. C.)

In reviewing the current agitation over medical care it would seem that there have been too few suggestions from members of the medical profession offered to take the place of state medicine. We cry: "Let us alone, we are perfectly alright as we are," when we know that is not strictly true. There are phases of good medicine that are not covered under the present system. It seems only reasonable that the doctors as a whole should be offering suggestions for improvement, rather than waiting for the public to ram undesirable legislation, like the Wagner bill, down our throats. Study of the Wagner bill causes one to believe that, while attempting to right some evils, it creates many more which need to be righted later. The Wagner bill is not the answer. Yet the American medical profession does not offer a scheme which would solve the need.

The problem of public health can be considered a problem of government. The problem of pri-

vate health as long as it does not materially affect the public, is a matter of the individual and his chosen physician. Unfortunately, those purveyors of the public health have tended to try to incorporate some of the private practitioner's duties, and thus have encouraged resentment. The physicians resent government control in common with the general population. Nowhere in the world is there as much resentment by such a group of highly trained professional men against control as in the armed forces. The doctors outside are fighting to stay out because they see what is happening to those in the armed forces. We in the armed forces do not blame them. We also see!

Instead of building up a large organization to enter into competition with the private physician, it is certainly possible to perform the duties of public health through private practitioners and, thus, get the job done without friction and without interference.

For instance, a practitioner can be given a certain amount of work to do in the interest of public health. This would include preventive medicine, sanitation, epidemic control and safeguards, water control, sewage disposal, and the examination of school children for the purpose of discovering defects and contagious diseases. When defects of a public nature are found, the practitioner can, with the force of a public health officer, enforce correction of the defects. When personal defects are found he can advise the patient or parent of the proper remedy and he is in a position to advise where such a remedy may be obtained, should he not be prepared himself to give necessary treatment. Thus, in public health the doctor becomes a public official while in matters of private health, he remains the family physician.

In this way, freedom of choice of the physician would be maintained. The patient-physician relationship would be kept on a high level. A physician, according to his choice, would or would not do public health practice. Physicians in smaller communities carry on public health functions whether they like it or not. Under this plan they would be paid for these services. With a guaranteed minimum income, varying with the population served, and paid from public health funds, rural communities would conceivably be better served by physicians. Most younger men now go to the cities. Perhaps that one problem, one of the most difficult, could be solved in this manner. Many physicians who would retire to the country might serve for a much longer period, merely working at a lessened pressure but giving

proper medical care to the more rural communities.

Such a scheme would probably not change the type of practice as city physicians now enjoy. A scheme which insists upon a man paying for his personal health services will help him to keep his self-respect and not contribute to the pauperization of large groups of people. With such a plan in effect, it is felt that many physicians would leave those places where there is an over-supply of physicians and go to the lesser-populated places.

The control of a scheme of this type should be directly by the county medical society. Minimal requirements and regulations can be allowed the public health organization, say through the state health officer, but the local physician would be partly responsible to his county organization. The details require considerable study and the correlation of experience and facts. It is obvious, too, that local adjustments would be necessary. The application of such a plan would vary with the community served and alteration of details would be required to fit the successful plan of one community to another community with divergent needs, economics, and sociological and geographical factors.

But the plan which:

(1) Affords a wider distribution of competent physicians,

(2) Maintains the present patient-physician personal relationship,

(3) Extends the public health to remote areas,

(4) Clearly distinguishes between the public health and the private health, as well as differentiates payment for these services,

(5) Does not make paupers of the public,

(6) Is adaptable to the area served,

(7) Affords ample opportunity for extending public health education—schools, sanitary inspections, etc.,

(8) Affords a wide extension of preventive medicine, deserves some thoughtful consideration.

If the above eight valuable services are provided, it follows logically that the greatest of these services,

(9) The lessening of disease and the growth of a healthy community, will also be provided, which is the aim of both the private practitioner and the government. This will leave public and private health in the hands of the practitioners of medicine, not the politicians.

It is possible to envision a small country-town office of a public-private practitioner. On stipulated days, he furnishes, free to everyone, gov-

ernment-supplied sera, vaccinations against smallpox, typhoid fever and diphtheria, the epidemic diseases. He discovers an early case of scabies, for example, and advises treatment, for which he makes a charge in line with the prevailing local fees and with the patient's ability to pay, which the physician well knows. There are public health posters on the walls showing how to avoid malaria, how to drain barns, proper human excreta disposal measures, and fly control procedure. Public health bulletins on prenatal care are available. The physician may make house calls in the morning, devoting the afternoon to private practice in his office, giving certain hours in the week to public health practice, morning or afternoon, or both. At intervals he inspects the town restaurant, the dairy, and advises a farmer on the construction of a sanitary privy. In September he inspects the school children for defects and contagious diseases. He may give health talks, find cases of developmental defects—club feet, tonsils, hernia. The school check-up is a good place to start in the eradication of tuberculosis by case-finding. As a public practitioner, he points out defects to parents who can then be encouraged to work out a method for their correction. Likely as not, the public physician will then be consulted as a private physician for institution of these corrective measures in the individual. In any case, the choice will be free. The public health is protected, the public is not pauperized nor exploited, public and private health is made more readily available for all communities and the physician is a free agent subject to the stimulation of interest in a personal patient and to that offered by successful competition.

These may not be new thoughts. They seem sensible. There is no need to fight for the fight's sake of which there is some indication. The politicians can be fought better with reason. Give the public what it has a right to expect, public health, and let them pay for their private ills according to local and proper custom. Such a plan can be adapted, with proper adjustments, to rural or urban communities.

EDITORIAL COMMENT

HAVE YOU WRITTEN YOUR COLLEAGUES IN SERVICE?

From a large number of letters received from our members in the service, The Journal has noted their enthusiastic reception of letters from

those of us back home. Such letters represent almost their only contact with the practice of medicine as they knew it in pre-war days. Home-sickness can affect adults as acutely as youth. Friends of ours are widely dispersed in the military service in this war. A note from you at home will bring them cheer and you the consciousness of a good deed well done. Censorship regulations do not permit publication of addresses of members overseas but letters sent in care of The Journal will be promptly forwarded.

COMING MEDICAL MEETINGS

Kansas City Southwest Clinical Society, Kansas City, October 2-4th, 1944.

Oklahoma City Clinical Society, Oklahoma City, October 23-26, 1944.

Southern Medical Association, Saint Louis, November 13-16, 1944.

COMMUNIQUE

September 1st, 1944

To the Editor:

I want to express my thanks for your attempt to keep us fellows in the service posted on the medical activities in Arkansas during our absence. I look forward to a letter each month as well as The Journal, and read both with a great deal of interest. Of course, I am not so far away as many of the boys, but I have found that only a few miles from Arkansas is a "long ways."

I am now "fighting" "The Battle of the Bureaus" here in Washington, or sometimes referred to as "The Battle of the Red Tape." Myself and the other doctors study and place the Bureau's endorsement on all the medical surveys for the enlisted personnel of the Navy and Marine Corps, I being the internist to pass on cases whose disability comes within the scope of internal medicine. It is very interesting work and offers an opportunity of obtaining a fairly accurate over-all picture of what is going on. However, this administrative medicine does get a little "old" at times.

Hoping we will all be back to a more or less normal existence in Arkansas again in the not-to-far distant future, I am

Sincerely,

R. E. McLochlin,

Lt. Comdr., MC., USNR

PROCEEDINGS OF SOCIETIES

The Ouachita County Medical Society met in regular monthly session at the Ouachita Hotel in Camden the night of September 7th. The following talks were given: "Fractures of the Femur," Walter Carruthers; "Pathology of the Lower Urinary Tract," H. Fay H. Jones, both speakers of Little Rock.

R. B. Robins, Secretary.

The Southeast Arkansas Medical Society met at McGehee August 20th for the following program: "Post-War Tropical Medicine," C. H. Winkler, and "Present Status of Blood Plasma," Paul C. Eschweiler, both speakers of Little Rock.

The Sevier County Medical Society was addressed at DeQueen September 12th by W. R. Brooksher, Fort Smith, on "The General Practitioner and the Diagnosis of Cancer."

C. E. Kitchens, Secretary.

The joint meeting of the Tenth Councilor District Medical Society and the Sebastian County Medical Society held in Fort Smith September 12th was addressed by Jos. F. Shuffield, Little Rock, on "Osteomyelitis."

Ralph E. Crigler, Secretary.

COMMUNIQUE

September 8, 1944.

To the Editor:

I have missed another boat and am now on detached duty to the * * *, assigned to surgical staff of * * * Hospital. It appears that we will be here for the duration plus six months, or whatever the demobilization plan calls for. J. B. Futrell has recently been assigned to this hospital.

Sincerely,

Wm. B. Harrell, Maj., M. C.

"COURAGE AND DEVOTION BEYOND THE CALL OF DUTY"

Through the cooperation of Mead Johnson & Company, \$40,000 in War Bonds are being offered to physician-artists (both in civilian and in military service) for art works best illustrating the above title.

This contest is open to members of the American Physicians Art Association. For full details, write Dr. F. H. Redewill, Secretary, Flood Building, San Francisco, California.

PERSONALS AND NEWS ITEMS

Lt. Woodrow E. Phipps, North Little Rock, is now serving overseas with a general hospital.

F. A. Corn has been discharged from military service and has returned to his home in Lonoke.

R. R. Kirkpatrick, Texarkana; Howard A. Dishongh and P. E. Thomas, Little Rock, and W. R. Brooksher, Fort Smith, attended the Aero Medical Association meeting in Saint Louis during September.

R. E. McLochlin, Little Rock, now on duty with the naval medical corps in Washington, has been promoted to lieutenant-commander.

Lt. James H. Mosely is now stationed overseas.

Dr. and Mrs. C. K. Townsend, Arkadelphia, spent a recent vacation at Rockaway Beach, Missouri.

J. C. Moore has moved from Helena to Dyersburg, Tennessee.

BORN—On July 24, a son, Stephen, to Dr. and Mrs. Hoyt Choate, Little Rock.

BORN—On July 25, a son, F. Lamar McMillin, Jr., to Dr. and Mrs. Lamar McMillin, Little Rock.

Harold J. Morris has moved from Little Rock to Pine Bluff where he is resident physician at the Plainview Housing Project.

Lt. L. T. Taylor, Star City, is now serving as flight surgeon with a Marine Squadron on the west coast.

Maj. Virgil E. Lyons, Little Rock, is now assigned to Headquarters, 153rd Medical Battalion, Fort Jackson, South Carolina.

Lt. James F. Lewis, Fayetteville, is now stationed at the U. S. Naval Training School, Stillwater, Oklahoma.

J. T. Matthews has been elected post surgeon of the Heber Springs post of the American Legion.

Dr. and Mrs. Carl A. Rosenbaum, Little Rock, spent a recent vacation at Lake Taneycomo, Missouri.

Dr. and Mrs. R. O. Norris, Tuckerman, spent a recent vacation at Lake Taneycomo, Missouri.

The Division of Maternal and Child Health, Arkansas State Board of Health, Little Rock, offers complimentary copies of "Maternal Care" and "Maternal Care Complications" to any physician who requests these.

Lt. Gilbert O. Dean, Little Rock, is now stationed at the Marine Air Station, Santa Barbara, California.

Bert L. Phillips, Little Rock, has been appointed Venereal Disease Clinician for the Arkansas State Board of Health.

Maj. John W. Smith, Little Rock, is now stationed at AAF Regional Station Hospital, Drew Field, Tampa, Florida.

C. A. Archer, DeQueen, spent a recent vacation at deep-sea fishing off New Orleans.

Capt. W. O. Loftis, Pochahontas, is now stationed at the Prisoner of War Camp, McLean, Texas.

COMMUNIQUE

August 29, 1944.

To the Editor:

Just received the June issue of The Journal in which Monfort gave me a good plug. I think he would be a good man to have around for an advance agent. When I left him, his hospital relieved ours, he was settling down to enjoy the comfort and luxuries of * * *. During the few days we were together state politics, medical profession and gripes were pretty well covered.

I am now on another "problem," being entertained by the Nips often, lately they have been using smaller bombs, if that means anything. Probably their Singer sewing machine supply is dwindling due to cessation of American import. The prisoners taken in here are more numerous than in the other campaigns I have been on. They are emaciated, diseased and subdued, having forgotten that they are to die for their ancestors. The hospital has taken care of several of them the past few weeks.

The Journal and letters are very much appreciated and enjoyed. Even the "Eastern Docs" read them.

Yours,

Friedman Sisco, Maj., M. C.

RANDOM THOUGHTS OF THE SECRETARY

August 20th. Tonight comes National Committeeman Robins with Margaret giving us behind-the-scenes tales of the Democratic National Convention together with the story of research at Salt Lake City where the Mormons proved that it was not the "getting but the finding" that got the best of one. This brought on Chamberlain's tale of the taxidermist and the pigeon, the technical details of which were confusing to the ladies.

August 21st. For the first time in two years, we again take off, fly and land an aeroplane all by ourselves.

August 25th. Le jour est arrive! Fifteen hundred days without laughter; fifteen hundred nights of troubled sleep have passed and Paris is free! Free from the clatter of boots of sloppy hordes and freed, despite the murderous grip of so-called super-militarists, by its citizens, peaceful French citizens. Surely France will understand that if this time, she does not go to Berlin, the Germans will again come to Paris.

August 26th. Comes Ken Thompson visiting on leave from the "hot" 11th Armored Division which he claims to be the best yet and the one which finally whipped the desert, at present an area of quiet and tranquility.

August 27th. With the Chamberlains where Aetna's Foster Vineyard conspires to deflate us by recounting his success at weight reduction and by innuendoes as to the value of a life insurance contract we hold and, to climax the affair, unduly disturbs the ladies by exhibiting tickets to about seven current shows in New York which he shortly plans to see.

September 4th. In oppressive heat gathering with the flight surgeons today in Saint Louis meeting Kirkpatrick and Phil Thomas and after a full day of this, we gladly return to our crowded train where we may expect comfort in a cool Pullman.

September 12th. Seeking DeQueen's Country Club from the air this afternoon, an almost fruitless search, but finally setting down on No. 9 fairway with inches to spare over the oaks near the tee, and then into town for a most encouraging gathering of the Sevier and Little River county members, most happy to note that this county society is maintaining regular and profitable meetings despite the war emergency. Homeward across the Ouachitas, the gusty air making it a busy time for this amateur pilot, but all accomplished after a fashion and then to meet with the Tenth Councilor District where Shuffield makes a good report on osteomyelitis.

OBITUARY

JESSE ARTHUR KING, age 57, Elaine, died in Ferriday, Louisiana, August 7th, 1944, after a prolonged illness. A graduate of the University of Arkansas School of Medicine in 1918, he had practiced in Phillips County for many years, forming a group for practice with his son, J. A. King and A. H. Maddox, both of whom are now in military service. Because of ill health, he retired from practice three years ago. Surviving relatives are his wife, two sons and a daughter.

CHARLES N. MARTIN, aged 90, died at his home in Warren, September 7th. A graduate of Tulane University of Louisiana in 1878, he had practiced in Bradley County for 56 years. He had been an honorary member of the Bradley County Medical Society and of the Arkansas Medical Society for many years. Surviving relatives are two daughters, two brothers and a sister.

DR. NED RUDOLPH SMITH, 60, prominent Tulsa psychiatrist and civic leader, died at St. John's Hospital, Tulsa, August 18, 1944, after an illness of more than a year. His death was attributed to coronary thrombosis and general ill health which followed earlier attacks.

Born in 1884 at Bethany, Missouri, Dr. Smith was a graduate of the University of Michigan. He was the holder of five degrees from that institution, which he attended after a varied career which included several years of school teaching. After his graduation he became associated with Dr. Arthur Hertzler at Halstead, Kansas, as director of the Neurology Department of the Hertzler Clinic.

Coming to Tulsa in 1928, Dr. Smith won quick recognition as a psychiatrist and neurologist. His interest in civic affairs and in organized medicine brought him many honors as he served in numerous positions of civic leadership. In 1931, he converted the old Oklahoma Hospital of Tulsa into a modern sanitarium. Two years later he founded Oakwood Sanitarium near Sand Springs, which became a leading institution for the care of the neurotic and insane.

Dr. Smith served as president of the Tulsa County Medical Society in 1934 and as a trustee for many years. He was associate editor of the Journal of the Oklahoma State Medical Association. For some years he had been president of the Tulsa Board of Health.

—Bulletin Tulsa County, Okla.,
Medical Society.

GERMAN SOLDIERS KILLED BY OWN MEN FOR SURRENDERING TO YANK

By Cpl. Charles A. Klein

Stars and Stripes Unit Correspondent

With the Sixth Armored Division in France, Sept. 1.—How three German soldiers were killed by their own men for surrendering to an American colonel who was later captured with the prisoners, has been related by Lt. Col. James W. Branch, of Hope, Ark.

Col. Branch, C. O. of medical battalion, was able to tell his story when he returned to his unit after his successful attempt of talking over 75 Nazis to surrender to him although he had been their prisoner for three days.

A speaking knowledge of both German and French and the constant pounding of the Nazis by the U. S. Ninth Air Force and artillery were accredited by the colonel for his success.

No Food, Little Water

With Lt. Kevin M. Rothrock, of Pasadena, Calif., an MAC; and T/4 John Boyan, of Piermont, N. Y., the colonel had started out in a jeep in search of a new area to set up a field hospital.

Entering a small French village, the three men were immediately warned by the Free French that the Nazis were still in the village.

Immediately they turned their vehicle around and headed back toward the next town. Halfway there they ran into an approaching column of German vehicles, which they were later to discover stretched for about seven miles and consisted of well over 1,000 Germans.

Hiding their jeep behind a monastery, the three men hid in a wheat field for over three hours while the column passed. They then drove the vehicle into a field, covering it with hay, and looked for a more suitable place to hide.

Finding a huge hole resembling a former gun emplacement, the men hid in it. Misfortune again met them, however, when another portion of this same column picked this particular field as a bivouac area.

For 28 solid hours, with no food and only a canteen and a half of water, the three men remained in the hole during this period. Col. Branch said that they were subjected to constant artillery fire from our own soldiers and bombing and strafing from American planes.

Finally five German soldiers discovered them during the air attacks and two of them were killed attempting to get to them. The three dove into the same hole with the Americans and, after a little persuasion by the colonel, they decided to become American prisoners. They told the colonel that if they were discovered they would be shot, so they were hid under a canvas in the rear of his jeep and the six started off again.

They met the enemy again after going only 75 yards. All six were taken prisoner and despite attempts by Col. Branch to convince the Nazis that the three Germans in the vehicle were casualties, they were placed on the side of the road away from the Americans.

These three, shaking with fear, were told to remain on the side of the road and the Americans were to be taken to the Germans' medical detachment to assist in giving aid to the wounded.

Just as the American captives turned to leave, three shots were fired directly behind them and that was the last they ever saw of their three Nazis who had been their prisoners.

Agrees to Surrender

For another day and a half the three remained captives of the Germans until finally the commanding officer of

the unit informed the medical officer they were departing and that he was to follow the next morning for Brest with the three Americans. Fifty Nazi soldiers and their officer also remained.

All during that night Col. Branch talked to the Nazi doctor, telling him that his patients were badly in need of morphine and blood plasma, and that his diminishing supplies would not care for them.

He finally succeeded in his argument and the officer agreed to surrender. Another two-hour argument convinced the officer in charge of the fifty soldiers that to hold out was useless.

According to Col. Branch, approximately 175 Germans were killed or died of injuries received during the attack.

—Stars and Stripes, September 2, 1944.

COMMUNIQUE

August 27, 1944.

To the Editor:

It seems from memory that I owe you a letter so will drop you a few lines now.

Everything seems to be going along well here. We are quite busy now with casualties. This section or platoon of this field hospital is getting quite a few casualties, predominantly surgical. I have charge of the surgery. My T/3 in surgery is a Camden boy and a damn good technician. His name is Reynolds and he knows Dr. Robins in Camden. We have lots of extremity work, empyema, abdominal wounds, sometimes doing as many as twelve to fifteen cases in one day. Our main difficulty is getting rid of or evacuating them as they hate to leave an American hospital.

Our food is good. We now have a nice two-holer and have built regular QM seats where you can sit and read which is certainly a pleasure. Have showers rigged up with barrels under which is a fire for heating water. Get to see a movie about once or twice a week. Saw "Miracle of Morgan Creek" last night, which was excellent. Mail comes to us about every seven to ten days.

Am sending a few ** currency notes. There is no silver or gold money, all paper. The rates of exchange (black market) runs from 185 to 200 to 1 of our money. It is spoken of as **, abbreviation for ** national currency. You will have to carry a suitcase full in order to buy anything due to exorbitant prices. Well, there is nothing to buy anyway. We never spend any money.

There is an old high school classmate of mine in Little Rock practicing with offices in the Donaghey Building, from Yazoo City, Mississippi. His name is Lamar McMillan. If you ever go up to see Fay Jones or Hoyt Allen, I would appreciate you saying hello to him for me. I have not seen him since we finished high school in 1925. Had a nice letter from him a while back. Incidentally, he is also a U. of Tenn. graduate.

Come three more days and I will have completed my first year overseas. I wonder what it looks like back home. Have not seen my wife and daughter in 13 months. Sure wish I could.

Am going to see Ann Sheridan and company Tuesday back at headquarters. It will be my first American woman seen since April when I saw a Red Cross girl at a distance. They are rare things in * * *.

News over our radio sounds mighty good now. Sure would like to be with American troops in France. Sure was a disappointment when we came over here and found we were not to be with American troops after all the training, etc. Would like to be with American troops anywhere period.

Lots of luck,
Hunter A. Causey, Capt., M. C.

COMMUNIQUE

September 13, 1944.

To the Editor:

For several months I have been planning to write and tell you how much I have enjoyed Random Thots and the other letters I have received.

Since my first two months in the service at the U. S. Naval Hospital at San Diego, I have been with the Marine Air Wing. My first tour of overseas duty was spent in the South and Mid-Pacific. I had an interesting year on the Samoan Islands and was on about nine islands in all while in the Pacific area. While in the Pacific area, I flew about 15,000 miles from island to island and learned a great deal about the various coral atolls and volcanic islands as well as about the Polynesians and other island peoples. Another interesting island was Wallis Island, where I worked for two months with a dive-bomber squadron. There are two large crater lakes on Wallis Island, and, believe it or not, duck hunting is good in the larger lake. The walls of the crater extend vertically upward for 150 feet, making the approach to the lake fairly difficult. My first view of this lake was with a young Marine flier named Benton from near Booneville, Arkansas. He zoomed down into the crater with me in the back seat of his Douglas Scout Bomber and then zoomed out while I was still contemplating life insurance rates, et cetera. This island was one of the worst I encountered for filariasis. I saw many cases of filariasis on Wallis and Samoa. On my way home I stopped off for a few days in * * * and had a chance to visit John Greutter. During the evening I spent with

John, he saw six cases of filariasis among Army personnel who had been stationed on various South Pacific isles.

Since returning to the States, I have been stationed with the Marine Air Wing on the west coast except for a four months' course in Aviation Medicine and Flight Indoctrination at the Naval Training Center in Pensacola, Florida. My next assignment will be overseas but I hope to have a few more months with my family in "foggy" California before my outfit moves out.

Sincerely,
Gilbert O. Dean, Lt., M. C., USNR
Marine Air Wing
Santa Barbara, California.

COMMUNIQUE

To My Doctor Friends at Home:

A similar beginning to the above is used by some of the doctors at home who have been good enough to write to us through the Arkansas Medical Society. Speaking for myself, and I'm sure many others, these letters are greatly appreciated. Please keep up the good work—it helps to keep us up.

Your being so nice to keep me posted on the goings-on at home, and today being the anniversary of my having left my family for overseas duty and this month marking my second year in the Army, I just couldn't resist the chance to give you a little of the low-down on overseas life, as I have seen it.

All in all it has been very easy for me over here, though there have been times when it was not so good. The trip over was very nice though we were very crowded. The last three nights on the boat we had alerts; the first was a bombing by enemy planes, the next night it was a sub and the last night was a false alarm. We landed in * * * and our second night there we really had our "baptism." The next little bit we alternated living in dust and mud. We soon left there though and moved to * * *. Since that time * * * has been my home, such as it is. We have had our good and our bad times here too, but you know me, I'm going to make myself as comfortable as possible wherever I am, and that's just what I have done.

I have been fortunate enough to do a little traveling, having been in * * * several times, back to * * * time and time again and * * * accepts me as a native. I was fortunate enough to be sent, not so long ago, to * * * for a so-called "rest" and now I'm just about to get rested up from my rest. I have seen * * * and, of course,

the * * *, which surpassed my fondest expectations. * * *, well, it was wonderful, the nearest thing to an American city since leaving New York.

My first week overseas I ran into Ellery Gay and then shortly thereafter I met Robert Whitehead. Then for a long while I heard or saw no other Arkansas doctors until not so long ago I received word that Doyle Fulmer was in a nearby hospital and got to see him before he left for home.

I hear they are yelping for more and more doctors in the Army. I guess they know what they are doing, but there are times when I think that the doctors who are in the Army now, could be more wisely used. Of course, it's very easy to be critical, and oh, well!!

Those of you who were in the last war remember the general feeling between the British and the Americans—that feeling is still in evidence. The Italians have accepted us as a necessary evil; they really like us very well though there are times when they let it slip that "if we had not gotten into the war, the war would be over by now," and of course you can't argue much with them about that.

This is very sketchy but maybe it won't be too long before this will all be over and I can bore you to death by my—"NOW WHEN I WAS OVERSEAS."

Yours,

Leo Aday, Capt., M. C.

COMMUNIQUE

August 11, 1944

To the Editor:

Please forgive this long overdue letter, but I do want to thank you for sending me The Journal for these many months. It has kept up with me faithfully and I appreciate it very much. I sure do enjoy the communiques and especially your Random Thoughts. Got a big kick out of discovering that my Dad was indulging in veterinary obstetrics up at Dr. Eberle's farm. That's something he hasn't told me about. Seems funny for a "D—eye doctor" to be doing but then I delivered one over here myself a few weeks ago. Only this one was a legitimate * * * one and not a calf. This outfit I'm in, when it goes into action, really gets up on the front lines and sometimes beyond. I've given first aid and evacuated wounded from under fire several times now and wouldn't exactly recommend it for a Sunday afternoon sport. After the first few battles the boys sort of get smart and our casualty rate has lowered. Lately we've treated more civilian sick

and wounded and wounded * * * than our own men. Once not long ago, a sergeant and I went up to pick up a wounded * * *, and seeing us armed only with a Red Cross flag, three very unwounded * * * insisted on surrendering to us. Some of our civilian customers pay us with this "poor man's cognac." One quart is distilled from 20 gallons of cider and is guaranteed to take the fuzz off one's teeth. We put some by mistake into the gas tank of our bantam the other day and it ate a hole right through the bottom. There actually has been one case of acute gastric hemorrhage from drinking too much of the stuff. Well here's hoping this war is polished off soon. I'm sure looking forward to coming back to Fort Smith and really starting practice of medicine. Tell my dad to stick to his specialty. Thanks again for The Journal and please keep it coming.

Sincerely,

Everett C. Moulton, Jr.,
Capt., M. C.

COMMUNIQUE

U. S. NAVAL TRAINING SCHOOLS (Y)

Oklahoma, A. & M. College

Stillwater, Oklahoma

Aug. 21

Dear Bill:

This is a personal note to say hello and to let you know my whereabouts. After doing part-time duty at the Mare Island Naval Hospital for a number of weeks while on patient status, I was given a temporary assignment there. I asked for duty at the hospital at Norman and got orders to the school here early this month. Expected to have some leave and a chance to visit home and run down to Ft. Smith but it doesn't seem to be working out that way. My wife and boys are having trouble getting down here from Boston—probably be here this week, though, and Jed has to start school the 4th.

This is a very pleasant place, of course, but duties are so light it's boring. Quite a change after 16 months with the Marines. I had good duty—was with a medical company (field hospital) during the whole time with the Marines. We had a very satisfactory experience in combat on Bougainville. I was in charge of the medical service and took care of an awful lot of cases. I never could quite get back on my feet after we returned to Guadalcanal to reorganize in January and was evacuated in latter part of March.

Had a short visit home (2 days) on my way here—first visit there in 22 months. Found my parents looking well; the doctors not so terribly

over-worked just now but they have certainly been so much of the time these last two years, as you all in Ft. Smith have been also, I'm sure. I wonder which is worse actually—being worked to death or being bored to death and separated from your family for nearly two years. I wouldn't mind a trial of work for a change.

Haven't received The Journal very regularly the past months—am looking forward to it, and to some catching up on a lot of reading.

Have a nice house here—Stillwater isn't so crowded now as it was a few months ago with the army flying school now gone from here and only the wave yeoman and radar schools left.

Hope to have a visit with you one of these days.

Yours,

Jim Lewis

COMMUNIQUE

July 29, 1944

To the Editor:

Your note containing note from Lt. Col. Porter received and was glad to hear from you. Also had a V-mail from you several days ago which I will answer at this sitting. You might say I am also located at 8th and Plum and will continue until the monsoons are over which will be in the next 30-45 days, I hope. Then maybe we can dry out and keep the green mold from growing on all our things.

In regards to the cobs we now have an adequate supply for we have been eating fresh boiled corn for a month twice daily. The only bad feature is that we are lacking in red cobs.

You are quite right about the ruggedness of this terrain, then not having sufficient food was worse. Rice t. i. d., was a bit on the unsavory side.

Thanks for Van Binns' address. I will drop him a line some time.

We are busy with * * * casualties and have a fair amount of extra surgery on GIs. I manage to have a nap every afternoon which is right up my alley.

We get news broadcasts each morning at 0730 and evening at 2100 hours. It looks like they are about to give the Germans the business and definitely getting set to give the Zips the business thereafter. Would certainly like to see it all finish and all of us come home.

It seems this is where I came in and will close for this time. Again I thank you for helping keep the morale up, and I am sure the other fellows you write are of the same opinion.

Best regards,

Hunter A. Causey, Capt., M. C.

COMMUNIQUE

To the Editor:

Jim McKenzie sent me your letter in which you stated you were unable to understand why I failed to attend the April, 1944 meeting of the Society and that officially I was listed as still at Dyersburg, Tennessee.

Of course, it is obvious that I couldn't attend the meeting as I arrived in * * * long before the time of the meeting, and on the second score, I thought I had informed you of my whereabouts. Maybe I did and the postman failed to get it through. Anyway, I've missed a good meeting and several issues of the best medical society Journal I know of, and I want to give you my address now so that I won't miss any future issues unless they pass me on the way back home, in that event, I am willing to sacrifice at least one issue of The Journal.

We should now arrange to have a * * * meeting of the state society. The attendance would be good if we could round up all of the medics from Arkansas that are on or near here.

I am getting along fine. Feel like I've completely missed one summer and would actually enjoy some hot, sultry Arkansas weather for a change.

You know as much or more about the war situation than I, except I've seen enough human traumatism to last me forever. This outfit handles evacuated patients (casualties) from * * * as well as Air Force casualties. With kindest regards and willing to bet I'll eat Christmas dinner in Arkansas,

Sincerely,

J. M. Martindale, Major, M. C.

VITULES ANNOUNCED BY WYETH INC.

Vitules is the big news in connection with Wyeth's special fall and winter campaign for its several vitamin products. In full-page black and white advertising and in two-page color spreads, Vitules are being announced for the first time to the drug trade and medical professions as "improved formula vitamin capsules." The formula is based on the "recommended dietary allowances of all essential vitamins as established by the Food and Nutrition Board of the National Research Council, for the moderately active adult male." The vitamin potencies are considerably in excess of the minimum daily requirements.

Another important announcement in the campaign is that Wymins, Wyeth's, popular polyvitamin capsules, are now available in vials of 30,

SOUTHERN MEDICAL ASSOCIATION MEETING

St. Louis, November 13-16

It was the expressed judgment of the Council at the annual meeting last November that Southern Medical Association meetings are essential, as essential in war times as in peace, if not more so—that physicians, civilian and military, need medical meetings. There are many reasons why the Council believes our annual meetings are essential. The Council was agreed that a meeting should be held this year unless conditions not then anticipated seemed to indicate a meeting should not be held. However, it charged its Executive Committee with the responsibility of a final decision for a meeting this year and the selection of the place of meeting. The Executive Committee met in St. Louis on April 4 and decided that there should be a meeting and accepted the invitation of the St. Louis Medical Society to meet in St. Louis.

The Executive Committee has reviewed and given careful consideration to a communication from the Office of Defense Transportation, Washington, dated June 21, 1944, file 612-9, signed by J. M. Johnson, Director, requesting a cancellation of all meetings not definitely war-connected. The Executive Committee feels that our meeting at St. Louis will be definitely war-connected, particularly as it relates itself to civilian practice in these war times. The committee holds to its original viewpoint that Southern Medical Association meetings are essential.

After a careful consideration of the above mentioned communication from ODT, the Executive Committee has decided to go ahead with plans for a meeting in St. Louis in November—it does not NOW, more than four months before the date of the meeting, consider the possibility of not having that meeting. The committee will consider this matter again the latter part of September or early in October, a month or six weeks before the date of the meeting, carefully reviewing the whole situation as it appears at that time, and will then decide whether or not the meeting will be held or called off. In the meantime, we are to go ahead with perfecting and completing plans for a meeting in St. Louis in November.

Tantalum plates, foil, screws and wire to repair broken bones, nerves and skulls will shortly be available to civilian surgeons through a recent allocation of the War Production Board, according to an announcement made by Dr. Gustav S.

Matheny, President of the Johnson & Johnson Research Foundation, New Brunswick, New Jersey.

The Johnson & Johnson Research Foundation is a non-profit organization, founded in 1940 to endow research in universities and hospitals and to disseminate summaries of findings to members of the medical profession. Dr. Mathey states that by an agreement between the Ethicon Suture Laboratories, Johnson & Johnson subsidiary, and the Fansteel Metallurgical Corporation of North Chicago, the availability of tantalum for civilian surgeons is assured at an early date.

Tantalum has assisted surgeons to return to active life many cases which in the last war would have been disfigured and incapacitated for life. Lost portions of the skull, ears, noses and other parts of the face are being replaced with tantalum. One veteran has a tantalum "belly wall." Nerves which control motions in arms and legs are stitched with tantalum thread and protected while healing with tantalum cuffs. Facial paralysis is relieved by small, saddle-shaped pieces of tantalum and wire used to pull the corners of the mouth to a normal position. This stops the unpleasant drooling and facial distortion which go with the condition. Cleft palates also are being corrected.

COMMUNIQUE

August 3, 1944.

To the Editor:

Received your July 24th comments on the "Brief" magazine and was glad you liked it. Wish I could say it is a publication of our outfit but it isn't. We just happen to get some of their transient trade and they just happen to give us some copies of their publication which I thought was interesting.

Was glad to hear the favorable word about my home town candidate for the Supreme Court. We have a powerful little radio station out here now and our interest is a little keener about the home front.

If I didn't mention it last time, I am now the medicine man for a bunch of natives and some garrisoned G. I.'s. Because you may not get out here very soon on a visit, I'm sending a souvenir of native handicraft so you can see they make the grade on other things than climbing coconut trees.

Carl C. Hanchey, Maj., M. C.



PHYSICIANS of the South have an urgent call to St. Louis for the annual meeting of the Southern Medical Association, Monday, Tuesday, Wednesday and Thursday, November 13-16 — a great wartime meeting. Medical meetings are essential, as essential in wartimes as in peace, even more so. Physicians, civilian and military, need medical meetings. At the St. Louis meeting, a streamlined essential wartime meeting, every phase of medicine and surgery will be covered in the general clinical sessions, the twenty sections, the four conjoint meetings, and the scientific and technical exhibits—the last word in modern, practical, scientific medicine and surgery. Addresses and papers will be given by distinguished physicians not only from the South but from other parts of the United States. Everything under one roof, the Municipal Auditorium.

REGARDLESS of what any physician may be interested in, regardless of how general or how limited his interest, there will be at St. Louis a program to challenge that interest and make it worth-while for him to attend.

ALL MEMBERS of State and County medical societies in the South are cordially invited to attend. And all members of state and county medical societies in the South should be and can be members of the Southern Medical Association. The annual dues of \$4.00 include the Southern Medical Journal, a journal valuable to physicians of the South, one that each should have on his reading table.

SOUTHERN MEDICAL ASSOCIATION

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It can help to steady those "erratic fires" . . .

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and in bottles of 100. Heretofore, this product was supplied mainly in bulk lots of 1,000 capsules.

Still another addition to the Wyeth vitamin line is Plebex Tablets. These are natural vitamin B-Complex tablets prepared from high-grade brewer's yeast.

A special \$51.87 deal with winter dating terms is being offered on a minimum supply of all of Wyeth's vitamin specialties.

In addition to advertising in drug trade and medical publications, an intensive direct mail advertising campaign is being carried on. This is being supplemented by intensive detail work among members of the medical profession by Wyeth's pharmaceutical sales staff.

Petrolagar now is being offered to the retail drug trade at the lowest price in the twenty-two years of its history as a popular "family" laxative.

With full-page advertising in leading trade and medical publications, Wyeth Incorporated is announcing, in addition to the usual discounts, a special discount deal of 10 per cent on each five-dozen purchase of 16-oz. Petrolagar. The offer became effective September 15 and will continue until November 13. The details include a convenient four-month Winter Dating plan.

On a national scale, Wyeth is supplementing the published announcement with an intensive medical detailing and direct mail campaign. The objective is to place a winter stock of Petrolagar in every drug store in the country.

Every druggist taking advantage of this unprecedented low cost Petrolagar deal will agree to use an attractive counter display which the manufacturer will make available. The display includes a liberal supply of attractively illustrated booklets emphasizing the importance of "habit time" in the management of constipation. Both the display and the literature have been ap-

proved by the Council on Pharmacy and Chemistry of the American Medical Association.

Before launching the campaign, Wyeth pre-tested the display and the literature in several types of drug stores, and they proved to have both eye-appeal and selling power.

The campaign has the cooperation of wholesale distributors, making certain low prices available to drug stores purchasing less than five-dozen lots.

Willard C. Shepard, of Chicago, one of the foremost contemporary American medical artists, has been appointed Art Editor of W. B. Saunders Company, Philadelphia and London, publishers to the medical, dental, nursing and allied professions.

Mr. Shepard studied under the great pioneer medical artist, the late Professor Max Brodel of Johns Hopkins University Medical School, Baltimore, and is widely known by the medical profession for his life-like illustrations of many medical books and medical journal articles. He is a native of New York state, attended Oregon State College and received his art education at the McLeod School of Art, Los Angeles, the Art Institute of Chicago and the Brodel School at Johns Hopkins University. Since 1916, he has been medical artist to the Rush Medical College and the Presbyterian Hospital, Chicago, and, for the past several years, a general faculty member of the Department of Illustration of the University of Illinois College of Medicine.

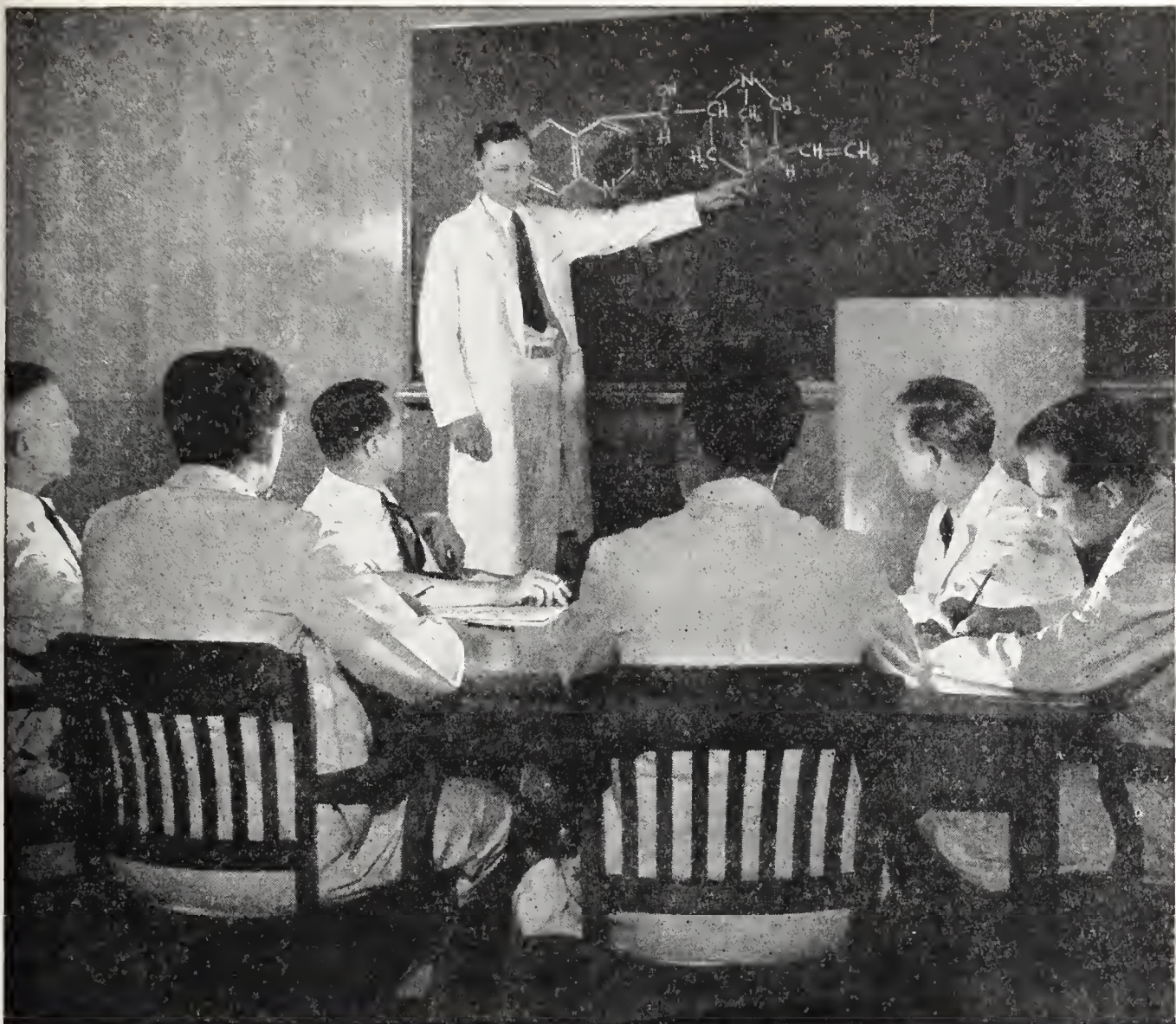
Mr. Shepard will have his studio in the main offices of W. B. Saunders Company on West Washington Square, Philadelphia, and will concentrate his talents on the more effective utilization of medical illustration to the benefit of medical education and clinical practice.

The latest contribution of this distinguished illustrator is a Manual of Surgical Anatomy in

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In antimalarial research we are seeking the drug which will be not only more satisfactory than present synthetics, but will be superior to quinine also. In the laboratories of Parke, Davis & Company, and on research grants, new chemical compounds are being synthesized, studied for toxicity, and tested for effectiveness against malaria parasites. We are looking for a non-toxic, rapidly acting drug that will be an effective prophylactic and a permanent cure for this disease.



PARKE, DAVIS & COMPANY  **DETROIT 32, MICHIGAN**

which he collaborates with Tom Jones, Professor of Medical and Dental Illustration at the University of Illinois. This manual will be published by W. B. Saunders Company under the auspices of the National Research Council and will be specially designed for use of medical officers of the armed forces.

COMMUNIQUE

August 8th, 1944

To the Editor:

Thanks for the letter. They are always welcome out here. Have been moving around quite a bit lately, mostly in one direction—north.

Just returned from leave to * * *. While in * * * I saw James R. Lamey of Indiana (Arkansas '36) and Ray Fulmer, the former heading for the States and the latter wanting to, but like myself, stuck for the duration. While in * * * ran across Stocker, also on leave, trying to work his way back to the officer's leave club aboard a tram. This is a problem not easily solved.

Captain Monfort, as far as I know, is in * * * using his skill fighting the land crabs and rats.

Please note change of APO.

Best regards,
Friedman Sisco, Major, M. C.

COMMUNIQUE

August 14, 1944

To the Editor:

For the past four years I have intended to write and thank you and the Society for The Journal. I truly appreciate both The Journal and the letters. Without them it would be difficult to keep up with many of my old friends.

Here's hoping that it won't be too long until we are all home again.

Sincerely,
Rogers Hedrick, Major, M. C.

BOOK REVIEWS

Technique in Trauma. Planned Timing in the Treatment of Wounds Including Burns. By Fraser B. Gurd, M. D., C. M., and F. Douglas Ackman, M. D., C. M. Pp. 68. Price \$2.00. Philadelphia: J. B. Lippincott Company, 1944.

This is a concise, well-written review of present-day practices in the management of burns, emphasizing teamwork and routine. Systemic and shock therapy is stressed. This book will be of much interest to the physician interested in burns.

TOM E. EVANS

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No. 6

THE DIFFERENTIAL DIAGNOSIS OF GLYCOSURIA FROM DIABETES MELLITUS.*

LUDOLF N. BOLLMEIER, M. D.

Hot Springs, Arkansas

and

ALBRECHT MEYER, M. D.**

It is a common clinical observation that in certain diabetic patients there are considerable fluctuations of urine sugar output and blood sugar, which do not always correspond to changes in the diet. Some authors refer to such fluctuating cases as "Emotional Glycosuria," demonstrating the changes of carbohydrate metabolism as the results of emotional factors. At present, we do not know with certainty whether or not this fluctuating type of emotional glycosuria and diabetes in which the sugar output remains on a stable level when untreated, are two fundamentally different conditions or only different phases of the same disease entity. From the practical point of view, however, it is most important to differentiate between these conditions because of the difference in prognosis and the necessity for different clinical management of the two.

The most important fact is that the condition called emotional glycosuria in certain cases at least is fully reversible. In the rapidly growing literature, many such reversible cases are quoted. William Menninger (11) reports five cases of disturbed carbohydrate metabolism in whom there was also a mental disturbance. These patients had persistent glycosuria and retarded glucose utilization curves of the blood sugar. With mental recovery the diabetic condition cleared, requiring neither insulin nor rigid diet. Menninger also reports another diabetic treated by Newburgh and Camp. A female, 32 years old, who

had a marked glycosuria and retarded glucose tolerance curve. This patient was treated by psychoanalysis, and her mental and diabetic condition cleared up. William Menninger (12) reports two cases of diabetes mellitus with mental disorders; both conditions cleared up together. One of the authors (Bollmeier) treated two cases of diabetes mellitus in whom the condition was reversed. The patient—female, 45 years of age, height 65 inches, weight 185 pounds, suddenly lost 35 pounds; the urine sugar output varied from none to two per cent, blood sugar was from 165 mg. to 250 mg. per 100 cc. blood. This condition, which developed while she had domestic difficulties involving her husband and her third daughter, continued for about one year. With the solution of these difficulties, the diabetes was reversed and she is at present, 11 years later, still in good health.

The second patient, female, developed diabetes at the age of 13. Upon examination six months after her mother's death, she was found to have glycosuria and a characteristic diabetic sugar tolerance curve which then was treated by diet and 50 units of insulin daily. She was married at the age of 24, had a child ten months later. After this the patient began to feel better and within six weeks the urine sugar output disappeared although no insulin was given. She continues in good health up to the present time (four years later).

Dr. Woodyatt (18) reported a case of diabetes in a young female in the hospital under observation. She fell in love with one of the internes, married him and the diabetes was reversed.

Daniels (3) reports a case of diabetes mellitus in a 35-year-old businessman who also suffered from a psychoneurosis for which he was treated by psychoanalysis. His blood sugar fluctuated up to 233 mg. and was low at times. Daniels concluded that the diabetes was a reversible condition and was connected with the neurosis. He also reports a case (4) of diabetes mellitus treated by Dr. Davis, Texas, in which the urine was four plus, blood sugar 370 mg. The diabetes was reversed and stayed normal for 18

* The research investigation for this article was carried out at the Institute for Psychoanalysis, Chicago, from 1937 to 1942.

** Research associate of The Institute for Psychoanalysis, Chicago.

Read before the Sixty-Ninth Annual Session, Arkansas Medical Society, Little Rock, April 18, 1944.

months; then suddenly reappeared with a new emotional upset. The diabetes was again reversed after the difficulty was discussed. In the same article another diabetic patient is reported that had been treated by Bauch, was a man of 45, who had been using 60 units of insulin daily; he became sugar free and remained so one year later. Daniel reports another case, a woman 43 years of age, who herself discovered that her diet had no relationship with her urine sugar output. On the days when she felt tense but kept to a strict diet she had four plus urine sugar, and on other days when she felt relaxed but paid no attention to her diet the urine would be sugar free.

Dunbar reports (6) several cases of diabetes. The one observed by Pris and Solomon was a male 27 years of age, who had suffered for years from glycosuria which could not be controlled even by a strict diet. After one injection of novarsenobenzal the glycosuria disappeared for three months, in spite of a liberal diet. It returned later, however, despite a strict diet and more injections of novarsenobenzal. The patient was reassured that he was not suffering from true diabetes, but that it was a renal diabetes; this seemed to be sufficient to eliminate the renal diabetes. The patient's urine was completely sugar-free after this. Subsequently, traces of sugar were found only twice; all other tests were negative during the nine months after the patient had become sugar-free. The "patient" was on an unrestricted diet, gained weight, and was in excellent general condition. Solomon had previously made a similar observation on a 20-year-old bride in whom glycosuria was accidentally discovered, to the great perturbation of the family and physicians. After the presence of diabetes mellitus had been emphatically denied and consent had accordingly been given to the marriage, the glycosuria disappeared completely with a mixed diet rich in carbohydrates. One case treated by Woodyatt (19), was a 65-year-old male who was in a hospital on a diet and insulin, passing normal urine. Suddenly he passed 43 gm. of sugar, another day 76 gm. The precipitating factor was that he had been informed that his corporation was taking steps to retire him. A man treated by Mohr passed 2½% sugar in urine. After the first hypnotic treatment patient was sugar free and remained so four years later.

Other observations concerning emotional precipitation of glycosuria are those of Tigerstedt who found glycosuria in ten out of a series of thirteen students before or after a six-hour exam-

ination; Maranon, who reports hyper-glycemia in aviators, varying in degree according to the extent to which individual aviators experienced fear; and finally, Knuer and Billingheimer who found that neurotic soldiers, as well as many normal soldiers, showed glycosuria for two to three days after being under rapid fire.

Judd, Kepler and Rynearson (8) reported a female patient, 43 years old, history of diabetes mellitus since 1926. The diabetes was controlled by a diet low in carbohydrate and 70 units of insulin per day. In 1930, periods of intractable glycosuria which did not respond to 600 units per day at times, began to alternate with periods of severe and prolonged reactions to as small a dose as 10 units of insulin. In 1931 insulin was discontinued. In 1932, spontaneous hypoglycemia occurred every few days. In 1933, hypoglycemia coma developed which lasted for two weeks. This was followed by marked personality changes. Exploratory laparotomy performed in 1933, the pancreas was found to be normal. In 1937, the episodes of hypoglycemia became more frequent.

Keating and Wilder (7) report a girl, aged 17 years, registered 1939, had diabetes of seven years duration which had been difficult to control because of the frequent reaction to insulin. Two years prior to registration, convulsions had occurred, accompanied by coma and sweating. At times, the value for the blood sugar had been low and at other times normal or high. The patient's personality was peculiar. Soon after leaving the clinic, the patient had a severe attack of hypoglycemia despite large amounts of solution of dextrose given intravenously, the blood sugar three hours later, was so low it could not be determined. Exploratory laparotomy was negative.

Different authors refer to their cases as diabetes, others speak of glycosuria. It is, however, not clear what is their basis of this diagnostic qualifications—except that there is a tendency to call a case glycosuria when the sugar output is fluctuating and diabetes when it is constant. The need for a differential diagnostic method is obvious, both from diagnostic point of view as well as from that of prognosis.

The influence of emotions upon the carbohydrate metabolism, is, apart from these clinical observations, well demonstrated by physiological experiment. Cannon (2) produced great rage in cats which they were unable to release. The experiment was repeated after destruction of the nerves of the liver. This gave the same result—increased blood sugar. Finally, the suprarenal glands were removed, and the same experiment

carried out. This produced a low blood sugar.

The review of the literature, both clinical and physiological, reveals very cogent evidence that glycosuria may be precipitated by emotional tensions; acutely in otherwise healthy persons and chronically in patients whose carbohydrate metabolism seems to be disturbed for a decidedly longer period of time, and are considered as diabetes. Therefore, it is of great practical importance that reversible emotional glycosuria be differentiated from irreversible diabetes. An early diagnosis will help the physician to give the proper treatment, i. e., by psychotherapeutic means with special reference to the environment, diet, and insulin, if required. It is quite possible that the irreversible cases of diabetes are the end results of a functional fluctuating phase, which after a certain duration may lead to irreparable damage of pancreatic function. According to this concept the course of certain cases of diabetes would follow the same principles which were postulated by Alexander and his co-workers for essential hypertension and peptic ulcers. (1) The hypothesis is that a fluctuating emotionally conditioned phase of hypertension gradually leads to vascular changes and this results in an irreversible condition. Also, the psychogenic concept of peptic ulcer assumes a period of emotionally conditioned dysfunction of the secretory activities of the digestive tract finally leading to structural changes.

Warren (16) states: "Few diseases definitely associated with any one function, metabolic or otherwise, show as wide a range of concomitant pathological change as does diabetes—or as frequent absence of demonstrable pathological change; many of the pancreases in diabetic children fail to show any definite pathological change." Also the post-mortem findings of Dry and Tessmer (5) point in the same direction (201 cases). They state that certain lesions of the islands of Langerhans are suggestive but not conclusive in the pathologic diagnosis of diabetes mellitus. They feel their study illustrates the inadvisability of generalization regarding any correlation of the microscopic appearance of the pancreas and the clinical severity or duration of diabetes. Long (8) points out at least 25 per cent of autopsies on diabetics reveal no pancreatic lesion nor does assay of the pancreas always disclose an inferior content of insulin. Since insulin will also abolish glycosuria due to a wide variety of agents, its effect in diabetes is not a specific one; and in consequence caution should be used in interpreting its action in this condition as any such proof.

If our concept is valid these controversial post-mortem observations have an obvious explanation. The structural changes are found only in the advanced cases, while the earlier fluctuating phase is still of functional nature, without detectable structural changes.

Waters and Best (17) of Toronto, stated that diabetes may not be due primarily to subnormal secretion of anti-diabetic hormones but to various other hormonal disturbances. Soskin's (15) statement based on experiments done since insulin has been available as a control, relates it is evident that diabetes is better explained by the theory of over-production of sugar by the liver than by the assumption of non-utilization by the tissue. The action of insulin is to regulate the rate of output of sugar by the liver rather than to accelerate the rate of utilization by the tissue. Mirsky (14) and associates of the May Institute, reported excessive carbohydrate intake does not produce diabetic coma. They think it is due to subnormal liver glycogen and any phenomenon which will accelerate the depletion of glycogen in the liver, will result in a secondary acceleration of the oxidation of fat and the consequent secretion of acetone bodies in the blood stream in excessive amounts. Two important observations have been made by independent workers that definitely connects emotional disturbances with the etiology, prognosis and treatment of diabetes mellitus. Joslin (9) finds "Negroes, once immune, recently many affected." Miller (13), who is connected with an Indian Reservation hospital, informed me that "full blooded Indians are practically immune, but in the mixed blood Indians, diabetes is common. The obvious explanation for these two very important observations, you will find in the well known psychoanalytical fact that neurosis is the price we pay for civilization."

At present, we do not have a method whereby a differential diagnosis could be made between true stabilized diabetes and emotional glycosuria. Our method of a daily examination of urine together with the emotional states, represent a reliable diagnostic test for emotional glycosuria. Emotional glycosuria includes all carbohydrate metabolic disturbances in which the urine sugar output and blood fluctuates primarily in response to emotional stimuli. Important is the fact that these cases are still reversible. Characteristic for these cases is that changes in the intake of carbohydrate has little influence on the blood sugar or urine sugar output; whereas emotional factors promptly release sugar output.

The prognosis for this group is obviously much

Chart No. 11
SUGAR (GM) ELIMINATED IN URINE
Breakfast— 8 A.M.
Lunch —12 N.
Dinner — 5 P.M.
Diet { Carbohydrate—150. gm
Fat — 75. gm
Protein — 75. gm
Patient No. 3 (Female, Age 50)

Urine Coll'd	Mon.	Tues.	Wed.	Thrs.	Fri.	Sat.	Sun.
8 A.M.	1.5	1.0	1.5	1.0	1.5	1.0	1.5
11 A.M.	2.0	1.5	2.0	2.5	3.0	2.5	2.0
2 P.M.	3.0	3.5	3.0	2.5	3.0	3.0	3.5
5 P.M.	2.5	2.0	2.0	3.0	2.5	2.5	1.0
8 P.M.	4.0	3.5	4.0	4.5	4.0	4.0	3.0
11 P.M.	2.0	2.5	2.0	2.0	1.5	2.0	1.5
TOTAL 24 Hrs.	15.0	14.0	14.5	15.5	15.5	15.0	12.5

SUGAR (GM) ELIMINATED IN URINE
Breakfast— 8 A.M.
Lunch —12 N.
Dinner — 5 P.M.
Diet { Carbohydrate—150. gm
Fat — 75. gm
Protein — 75. gm
Patient No. 4 (Male, Age 60)

Urine Coll'd	Mon.	Tues.	Wed.	Thrs.	Fri.	Sat.	Sun.
8 A.M.	3.5	4.5	4.0	3.5	4.0	3.5	4.0
11 A.M.	8.5	9.0	9.0	10.0	9.5	10.0	9.0
2 P.M.	9.5	8.5	8.5	9.5	10.0	9.0	10.5
5 P.M.	7.0	6.0	7.0	7.0	7.0	7.5	6.0
8 P.M.	11.0	10.0	11.0	10.0	10.5	11.0	11.0
11 P.M.	5.0	4.5	4.0	5.0	4.0	4.5	5.0
TOTAL 24 Hrs.	44.5	42.5	43.5	45.0	45.0	45.5	45.5

The charts numbers 1 and 2 represent one week observation on two fluctuating cases. Charts 3 and 4 show two irreversible cases of diabetes. The difference between the cases is more impressive if the sugar outputs at the same hour of the day are compared with each other on consecutive days. In the cases of established diabetes, the sugar output at the same hour of the day remains about the same during the whole week. In the fluctuating cases, the sugar output one day at 8 a. m. might be 20 gm. and another day nothing.

This test in the stabilized cases of diabetes may be helpful for the physicians for timing precisely the use of insulin, since in these cases the peaks of sugar output fall constantly at the same time of the day. The prognostic value of this test has already been mentioned and we shall come back to it.

Interpretation of the Test

In charts 1 and 2 there are represented two laboratory reports for two patients for a period of one week of examination. On chart 1 the

patient had a negative urine sugar on Monday at 8 a. m.; on Tuesday at the same time he eliminated 2.0 gm. sugar; on Wednesday at the same time there was 1 gm. sugar. The same patient eliminated 1.0 gm. sugar Monday 8 p. m., three hours after his heavy meal. On Tuesday at the same time it was sugar-free; on Wednesday, same time, it contained 4.0 gm. sugar.

Chart 2 gives us a similar picture. The sugar output changed every day and it never had any regularity when eliminated, nor did it have any connection with the carbohydrate intake. One would expect a low sugar output in the morning but these patients some days, have the highest output of sugar at this time. (Fifteen hours after their intake of food.) On the other hand, the 11 p. m. specimens only six hours after the heavy meal are negative at times. These constant changes of sugar output during the day and the different amounts eliminated during the different parts of the whole 24 hours are differential diagnostic criteria. These patients who show such inconsistent fluctuation independent from meals and insulin medication are those who suffer from emotional glycosuria. To use an expression of Dr. Woodyatt (19), it is as if one could measure quantitatively the power of emotions in terms so tangible as ounces of sugar.

In charts 3 and 4 there are two laboratory reports about two patients extending over one week each. The patient reported on chart 3 eliminated 1.5 gm. sugar Monday at 8 a. m.; Tuesday, same time, 1.0 gm.; Wednesday, same time, 1.5 gm. On Monday, 8 p. m., three hours after his big meal, 4.0 gm. sugar was eliminated. Tuesday, the same time, 3.5 gm.; Wednesday, the same time, 4.0 gm. Patient on chart 4 offers a similar picture; the sugar output is always about the same at the same hour of the day and there is little change as to whole amount eliminated during 24 hours. The carbohydrate intake has a greater influence upon the sugar output of these patients than those reported on charts 1 and 2. The morning sugar output is generally lower than it is the rest of the day. The patients in this group have a definite stabilized sugar output and very little oscillations. They belong to the stabilized ("true") diabetes mellitus class, and probably are those who show definite pathology of the pancreas.

Diagnostic and Prognostic Value of the Test

The test differentiates between emotional glycosuria and stabilized diabetes mellitus which is of great importance for both prognosis and treatment. Patients suffering from emotional

glycosuria have an unstable emotional life and must be under constant clinical and laboratory supervision (daily quantitative sugar urinalysis) in order to control their diet and insulin and to prevent hypo- or hyper-glycemia. At the same time these patients are in need of expert psychotherapeutic help.

From the prognostic point of view it is important to know that this type of glycosuria is a reversible condition. Such patients may remain sugar free even after discontinuation of insulin. Apart from spontaneous recoveries which may occur with certain changes in the patient's life conditions, psychotherapy has in these cases great therapeutic possibilities.

The stabilized (true) diabetes mellitus group from the therapeutic angle offers a simpler problem. They have a constant output of urine sugar. After their condition is stabilized on a diet and the proper dose of insulin established they need very little checking as compared with the emotional glycosuria group. Though the basic condition cannot be therapeutically influenced, even in these cases the test is of therapeutic significance indicating the correct timing and the amount of insulin medication.

Conclusion

Emotional glycosuria can be well differentiated from established diabetes by two criteria: (1) Fluctuations of the sugar output are more influenced by emotional factors than by carbohydrate intake. This is most clearly demonstrated by such observations as described in chart I, in the case of a patient whose urine at 11 p. m. was sugar free, but the next morning at 8 a. m. it contained 6 gm. It is obvious that we deal here with a mobilization of stored sugar under the influence of emotional factors. (2) Emotional glycosuria is a reversible condition. Such findings as Warren's concerning the extreme variability of pathological post-mortem findings in diabetes find, in the light of this study, a ready explanation. Emotional glycosuria is a functional condition and consists in the mobilization of stored sugar under influence of emotions. There is a possibility that certain cases of diabetes develop as the progressed phase of a functional disturbance (emotional glycosuria) as a result of an over-taxation of the regulatory mechanisms of sugar metabolism.

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COMMUNIQUE

Sept. 26, 1944

To the Editor:

Your stories in the latest overseas "Random Thots" have provided much amusement for all of us. Thanks a lot. Here is a true story: One night I removed a perforated appendix, a rotten one; the nurse gave it to the "circulating" corpsman, who placed it on a table. When we looked for it after the operation, it was gone—we saw a rat streaking across the floor with it! Some way to poison rats, eh? Best regards to all.

John J. Monfort, Capt., M. C.

MODERN CONCEPTS OF CARDIO-VASCULAR DISEASE

COMMITTEE ON THE HEART ARKANSAS MEDICAL SOCIETY

C. T. Chamberlain, M. D., Chairman, Fort Smith

Increase in travel by air is inevitable after the war. At the present time we, as physicians in civilian practice, are seeing each day larger numbers of individuals serving with the armed forces who have experienced high altitude flying, power diving, etc. Presumably these individuals have normal cardiovascular systems. Some, however, are being discharged because of defects that have developed in their circulatory apparatus which may or may not have come about as the result of their flying experience. Undoubtedly, in the future we shall see larger and larger numbers of these patients following the termination of the present world-wide conflict. For that reason the Heart Committee has chosen for publication in the Journal the following summary of "Aviation and the Cardiovascular System," by Bauer, and published as No. 2 of the Volume XII in "Modern Concepts of Cardiovascular Disease."

The committee feels that the profession generally will find this summary not only interesting but instructive:

The general effects of flying on the cardiovascular system are practically nil if we exclude the effects of high altitude and high speed. There is no evidence that continued flying has any deleterious effect on this system until we begin to suffer from the effects of oxygen want or change of direction at high speed. Hence, this article will be devoted to a summary of these phases of aviation medicine.

One of the early effects of oxygen want is noted in an increased pulse rate. The pulse continues to accelerate until the subject's altitude limit is reached. If the individual remains at an altitude below his critical level for any length of time, the pulse slows somewhat but never reaches its ground level. The amount of increase depends on the rate, height and duration of ascent. This is interpreted as an effort to get more oxygen to the tissues by increasing the rate of circulation. It also, according to Schneider, is a sign of probable distress. If oxygen be administered, the pulse rate immediately returns to normal. The tendency for the rate to drop after remaining at a specified altitude is explained by Schneider and Havens as due to a reserve supply of red corpuscles being thrown into the cir-

ulation, thereby providing a greater oxygen carrying capacity. When the limit of altitude is reached, some subjects faint, and others become unconscious before fainting.

The blood pressure is affected in various ways. There may be no alteration or a gradual rise until a height of 12,000 to 15,000 feet is reached. Then one of the following changes may take place: (1) A further increase of the systolic and a gradual decrease of the diastolic pressure; (2) an abrupt increase in the systolic pressure, an increase in the diastolic or in both, followed by an abrupt break in one or both with fainting and circulatory collapse. The increased pulse pressure is also interpreted as a sign of distress. At sustained altitudes of 8,000 to 16,000 feet there is a tendency for the blood pressure to return to normal levels. Again, these developments are cut short by the administration of oxygen.

The effects on the heart itself have been studied by various workers. In the early days it was always assumed that high altitude had a bad effect on the heart and patients with heart disease were advised to avoid high altitudes. It was also noted that a number of cases of fainting and collapse occurred at high or simulated high altitudes.

The earliest work was by Whitney, who concluded that there is heart failure following marked cardiac dilatation. He felt that the heart itself was vulnerable to the effects of oxygen deficiency. He thought he could detect dilatation of the heart by percussion.

Two years later LeWald and Turrell undertook a series of experiments in which Roentgen photographs were taken of the heart at every 1,000 feet of altitude. They found that forced inspiration and expiration alone accounted for a difference in the transverse diameter of the heart of at least 3 cm. In most of their cases not only was there no increase in the size of the heart at collapse but the heart was actually smaller due to the blood being largely in the splanchnic area.

Greene and Gilbert did the earliest work on the electrocardiogram. They found that the changes due to oxygen want were slight until the critical stage was reached. Briefly, their findings were: Precrisis changes showed shortening of the P-R interval, decrease in the total time of the R-T interval and a decrease in the amplitude of the T wave. Postcrisis changes showed slowing of the rate, displacement of the pacemaker and interference with normal conduction leading to dissociation. The postcrisis rate dropped sometimes five or more per minute and was as-

sociated with the development of auriculo-ventricular rhythm.

All this work of Whitney, LeWald, Greene, and Gilbert was done over twenty years ago.

Recently, Armstrong has said, "The effect of anoxia on the heart muscle is the same as that for any other tissue and the heart will continue to function long after the respiratory centers have become paralyzed. The EKG changes from anoxia consist essentially of a lowering or inversion of the T waves, a depression of the R-T interval, and sometimes a deformity of the QRS."

Kountz and Gruber have shown that anoxia produces characteristic changes in the EKG, the initial change observed by them being a decrease in the amplitude of the T wave followed by inversion if the anoxia is progressive—the latter occurring usually at 30 per cent unsaturation of the arterial blood. Other workers have reported the same findings plus a depression of the RT segment. Graybiel reported slight variations in the P-R interval and QRS complexes.

Benson found that there were no changes in the EKG up to 30,000 feet if oxygen were administered.

Still more recent work on this subject has been done by White. Forty-five subjects were exposed to altitude flights without oxygen. Two series were studied. Twenty-five were exposed to 20,000 feet, half ascending to that level in one hour, the other half in two hours. The second group of twenty was taken to 15,000 feet and held there for two hours.

In the 20,000 feet group there was a progressive diminution of the height of the T wave in all subjects in all four leads. This decrease in height began as low as 5,000 feet. With the administration of oxygen, there was a restoration to normal height. In the 15,000 feet group there were similar changes but a tendency to return to normal noted. One case developed a shift of the pacemaker. As a rule in the group that ascended more slowly the changes were lessened.

As a result, White recommends the use of oxygen at 7,500 feet as a precaution.

Albers and Koch report the following electrocardiographic changes: Changes in the height of the P wave, lowering of the voltage of the QRS and lowering of the T wave. The ST level was lowered in about one-fifth of cases.

Dill and his associates at the Harvard Fatigue Laboratory state that when benzedrine is administered during exposure to low oxygen tensions, there is a slight increase in pulse rate. Benzedrine has a favorable action in preventing the fall in blood pressure during anoxemia.

The electrocardiographic alterations following the administration of benzedrine are slight. This drug tends to prevent the lowering of the T waves which may occur during exposure to low oxygen tensions.

In 1937 Bishop made a study of the question "Is it safe for the heart patient to fly?" The sum and substance was that there were two factors to be considered in the case of the cardiac—one the psychological factor associated with the apprehension of first flight; the other, oxygen want associated with high altitude. Apprehension causes acceleration of the heart rate and in the hypertensive and potential hypertensive an increase in blood pressure.

In a person accustomed to flying and who is philosophic about it, there is no more danger in flying than in going by auto or train except for the effects of altitude, which can be relieved by the administration of oxygen.

Graybiel states that there is no evidence that the normal heart is affected by altitude. In susceptible persons peripheral failure may occur and this is evidenced by circulatory collapse. In persons with diseased hearts there is definite evidence that anginal or even congestive heart failure may occur, but only in those cases with considerable heart disease who are exposed to the oxygen deficiency of levels of 14,000 or more feet. This, of course, may be prevented by the use of oxygen before such levels are reached. Graybiel concludes that under the conditions of civil or military aviation the normal heart is not damaged, and that only patients with severe heart disease might be advised against flying on commercial planes.

Smith of the Mayo Clinic found 93 cases of coronary sclerosis in 1,831 consecutive clinical records of physicians, bankers, lawyers, clergymen, laborers and farmers. The incidence of coronary sclerosis by groups was as follows: Physicians showed a rate of 10.7 per cent, bankers 5.3 per cent, lawyers 4.6 per cent, clergymen 4.6 per cent, laborers 2.6 per cent, and farmers 2.6 per cent. The incidence in all classes of mental workers was 6.3 per cent compared to an incidence of 2.6 per cent in all classes of physical workers. Leedham feels that flying as a pilot with its tremendous responsibilities such as property, lives, schedules, mental strain plus irregular hours makes it in a class with the practice of medicine and the degenerative hazards will be about equal.

At extreme altitudes above 30,000 feet the effect of lowered barometric pressure is added to that of oxygen want. This low pressure results

in what has been termed aero-embolism and aero-emphysema. Pathologically, it is the same as Caisson disease or the "bends," and air emboli may lodge in the blood vessels of the brain, coronary vessels or other terminal vessels. Prevention is by breathing pure oxygen from the ground up and till return to the ground, and for as long as possible up to one hour before departure. The emboli are nitrogen bubbles released at low pressures and nitrogen can be partially replaced in the system by oxygen. Hence the recommendation to use oxygen as outlined.

There is also an effect on the circulation in acceleration and deceleration as experienced in acrobatic flying, in turns at high speed and in dive-bombing. Those circulatory changes are due to centrifugal force. In positive accelerations there results cerebral anemia due to a pulling of the blood to the splanchnic area and to the extremities, while in negative accelerations, there results cerebral congestion. In the first, the pilot sees "black"—in other words, passes out completely—in the second, he sees "red" and, actually, retinal or brain hemorrhages are a possibility.

Positive accelerations are the ones usually dealt with, such as occur in turns at high speed in racing, acrobatic maneuvers and in pull-outs from dive-bombing. The effects can be lessened by having the pilot wear an abdominal belt which can be inflated, exerting sufficient pressure against the abdomen to prevent pulling the blood away from the upper part of the body; by placing the pilot in a crouching or nearly prone posture, so that the force strikes his body transversely instead of from the head to the feet, and by having him yell loudly, fixing his diaphragm, thus helping to retain some of the blood in the head.

In summary, therefore, we may state that flying per se has no effect on the cardiovascular system. The effects noted are all due to the low oxygen or low barometric pressure of high altitude and the mechanical effects of high speed, the latter the result of centrifugal force. Oxygen is the preventive and cure of the first group and mechanical devices and methods the preventive and cure of the second.

Acknowledgment is hereby made of permission by the American Heart Association to publish the above.

COMMUNIQUE

September 16, 1944.

To the Editor:

Received your V-mail of the sixteenth of Au-

gust the day that I left for ** and then got "Random Thots" a couple of days after I got back. Was so far behind with my correspondence when I got back that I am just now catching up with it.

I guess that Dr. Martindale is still on the island but I have not heard from him in the past two weeks. Did hear through Royce Weisenberger that Dr. Branch was in ** and had had quite an experience. Was captured for a while and then talked the Jerries into surrendering. Quite an experience, I imagine.

I really enjoyed the jokes in "Random Thots." Showed them to quite a few of my pilots and also the boys at sick quarters and all of them enjoyed them, too. While in ** I heard Tommy Trinder again. I guess you could call him the Bob Hope of **. He told the story that I may have told you before, about the farmer who bought a fine registered bull for 1,000 pounds and took him home and put him in the pasture next to his beautiful cow, separated only by a barb wire fence. The bull saw the beautiful cow and just decided to jump the fence to go see her. However, he didn't quite jump high enough and the next day the farmer sold him for a ten-pound note. That was where the joke ended the first time I heard it, but the other night, after the crowd settled down again, he added, "Yes, you know the farmer couldn't use a bull with a broken leg."

The Journal is coming quite regularly. Takes it some weeks to get here but it finally makes it. Haven't missed an issue yet.

Keep "Random Thots" coming.

Sincerely,

Jim McKenzie, Capt., M. C.

COMMUNIQUE

September 14, 1944.

To the Editor:

Just received August "Random Thots" and just before leaving **, had the letter from Fay Jones. Had hoped to reply to that one but this may suffice until a little later when I shall try to write to Dr. Jones. Thought it very good of him to give us so much news. Learn that Arkansas has a new senator and governor, or rather will in January. Thought from the tone of Fay's letter that he might be coming out as a dark horse for some office! This is our first experience in an Allied country **. Haven't been here long but have learned that "socialized medicine" is in vogue. Will try to learn more of it.

Regards,

A. M. Washburn, Lt. Col., M. C.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

A NEW disease of the respiratory tract has captured a place upon the medical scene during the past decade. Primary atypical pneumonia—to give it the name which seems most commonly used—has probably existed for years masquerading as atypical influenza or grippe. With the increasing use of X-ray films in diagnosis the prevalence of the disease has begun to emerge and its importance to be recognized. The danger would now appear to be that it is as yet incompletely differentiated from pulmonary tuberculosis and that, unless progress film studies are carried out, some cases of tuberculosis will be treated for pneumonia and some cases of pneumonia given tuberculosis therapy.

ATYPICAL PNEUMONIA SIMULATING PULMONARY TUBERCULOSIS

For many years it has been the teaching of the medical profession to regard a patient subacutely ill with infiltrations of the upper lung fields in X-ray films as probably tuberculous unless proved otherwise. Recently it has become apparent that atypical pneumonia can produce lesions which at times are indistinguishable from pulmonary tuberculosis. This has been reported on several occasions. With the apparent increase in the incidence of atypical pneumonia, especially since the profession is becoming more conscious of it, it is evident that criteria for a differential diagnosis of these two conditions should be formulated.

Clinical Observations

The symptoms and clinical signs of atypical pneumonia have been adequately described in the current literature. The usual gradual onset of the disease, associated with malaise, generalized aches and pains, dry, nonproductive cough and fever may be simulated by any case of acute pneumonic tuberculosis. A differential diagnosis cannot be made solely on the basis of the history and physical examination. Where serial roentgenograms are not feasible, the persistence of cough and expectoration, plus the finding of rales for a period greater than 21 days from the onset of the disease, should lead one to suspect tuberculosis, even though the patient appears to be much improved.

Roentgenological Aspects

In our seven cases of upper lobe atypical pneumonia two types of shadows were found on the

films. The most common was an increase in the bronchial markings manifested by linear streaking densities with super-imposed mottled shadows. This was most marked at the hilum and, with an extension of the disease, would spread toward the periphery of the lung fields. The other type of finding was an area of increased tissue density in the parenchyma of the lung relatively uniform throughout and resembling the shadow seen in early pleural effusion. X-ray evidence of atelectasis was found in our cases only when the entire right upper lobe was involved. Complete involvement of an upper lobe will usually reveal some associated evidence of atelectasis, whereas in complete consolidation of a lobe due to pneumonic tuberculosis this is usually not the case. Because there was such a wide divergence of roentgenological findings in our cases of atypical pneumonia it was felt that we could not make a definite differential diagnosis from a single film. In serial X-ray studies it was observed that cases of atypical pneumonia could be expected to show complete clearing of the chest involvement in from four to twenty days. If the serial roentgenograms still reveal a density 20 days after the onset of the illness, pulmonary tuberculosis must be seriously considered even if other evidence favors an X-ray diagnosis of atypical pneumonia.

Case Reports

Case I.—A white soldier admitted to hospital with a one-day history of generalized aches and pains, headache, malaise, fever and chilly sensa-

tions. The physical findings were normal except for a moderate injection of the pharynx; the temperature was 100° F., pulse rate 82, respirations 20 per minute. The white blood cell count was 9,200, with 72 per cent polymorphonuclears. The working diagnosis was influenza. The patient continued to run a fever reaching 103.8 two days later. Within four days he had developed a non-productive cough. Physical examination at this time revealed suppressed breath sounds with an occasional fine moist rale in the right upper lobe. A chest X-ray showed complete consolidation of the right upper lobe. This had almost completely cleared within a week's time though the fever persisted somewhat longer. Recovery was uneventful and the patient was discharged to duty on the twentieth hospital day.

This case illustrates the difficulty of making a definite diagnosis roentgenologically. Bacteriologic examinations were negative and the rapid clearing of the lesion ruled out tuberculosis.

Case 2.—A white soldier was admitted to the hospital with a two-day history similar to that above. Admission temperature 101° F., pulse rate 100, respirations 20 per minute. The white blood cell count was 6,800 with 64 per cent polymorphonuclears. The working diagnosis was influenza. A chest film made four days following the onset of the illness showed marked increase in the hilar shadow with marked mottled densities throughout the right upper lobe. In one area there was a shadow with a central highlight suggestive of cavitation. The film made 15 days following onset showed complete clearing of parenchymal lesions.

Because of the suspicious X-ray suggesting cavitation, sputum and gastric studies were made. All were found to be negative for tubercle bacilli. The patient made an uneventful recovery and was discharged on the twenty-second hospital day.

Case 3.—A white soldier was admitted to the hospital with a history and physical findings similar to cases 1 and 2. The working diagnosis was atypical pneumonia of the right upper lobe. This was confirmed by roentgenogram. The patient had a low-grade fever for eight days following admission. A roentgenogram taken on the eleventh hospital day showed some clearing of the pneumonic process. The persistence of physical signs in the chest and the slow clearing of the chest lesion despite clinical improvement of the patient are not usual in atypical pneumonia so sputum examinations were begun. Tubercle ba-

cilli were found. This was confirmed in later examinations of the sputum.

Summary

1. Atypical pneumonia may simulate pulmonary tuberculosis both clinically and roentgenographically, and the reverse is equally true.

2. Approximately 7 to 10 per cent of atypical pneumonias have upper lobe involvement, which is the usual site for pulmonary tuberculosis.

3. Serial roentgenograms showing apical lesions failing to clear in 20 days, following the onset of the disease, should raise the suspicion of pulmonary tuberculosis.

4. Sputum studies for tubercle bacilli are indicated in all doubtful cases.

5. If lesions persist for 20 days from the onset of the illness, and routine sputum studies are negative, further studies should be done, that is, sputum and gastric concentrates, and guinea pig inoculation.

6. Because of the apparent increase in the incidence of atypical pneumonia, the need for an early differential diagnosis is imperative.

Atypical Pneumonia Simulating Pulmonary Tuberculosis, J. S. Yoskalka, American Review of Tuberculosis, May, 1944.

COMMUNIQUE

September 10, 1944.

To the Editor:

The sciatica has me bad and I can't think up any funny jokes like you and the uptown doctors that send us our very welcome news letters. I will probably move in with Bennett and Corn at Army and Navy and if I do, there's going to be singing, and good. Seriously, this climate is good for no man and the boys that own and operate over here haven't heard of rotation, so there's many of us that have succumbed to 3 summers of tropical heat and are coming home as patients. But you can hold up my Journal as I expect to be seeing you before too long.

Regards,

Fount Richardson, Maj., M. C.

COMMUNIQUE

September 19, 1944.

To the Editor:

The war has practically gone off and left us and if it were not for an occasional native OB case, I would have decubitus ulcers. Who knows, in another year, I may be demobilized at Chaffee?

Yours truly,

C. C. Hanchey, Maj., M. C.

THE JOURNAL

OF THE

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EDITORIAL

SCHOOL ESSAY CONTEST

Attention is directed to notice of the school essay contest sponsored by the Auxiliary at the request of the Society, notice of which appears in the Auxiliary section of this issue of The Journal.

The House of Delegates in its 1944 session agreed to the suggestion that such a contest would prove to be a great influence in acquainting the citizens of the state with the harmful effects of governmental medicine if applied to the country. In perhaps no other manner can more people be brought to the realization of the personal loss which will be theirs if government undertakes control and direction of the private practice of medicine. It is the obligation of the medical profession to fully publicize the dangers to free enterprise resulting from such plans as are now proposed.

The subject chosen for the essay contest is "Senate Bill 1161: A Menace to Medical Welfare." The contest is open to high school and college students in the state and \$300 has been set aside for prizes. Each member of the Society is urged to give this contest wide publicity, and to endeavor to secure as many student entries as

possible. The Auxiliary needs the help of the doctors. Let us not fail them in this work.

COMING MEDICAL MEETINGS

Southern Medical Association, St. Louis, November 13-16, 1944.

Southern Chapter, American College of Chest Physicians, St. Louis, November 13th-14th.

FEDERAL TUBERCULOSIS CONTROL PROGRAM

By recent legislation in Congress, the United States Public Health Service has been authorized to set up a Tuberculosis Control Division. Dr. Herman E. Hilleboe, who has been in charge of the tuberculosis control activities of the Public Health Service since 1942, has been named chief of the division.

The Public Health Service has announced the inauguration of a national program comparable to the national program for venereal disease control. The division will function along the following lines:

(1) Developing more effective measures for the prevention, treatment, and control of tuberculosis.

(2) Assisting states, counties, health districts, and other political subdivisions of states in establishing and maintaining adequate measures for the prevention, treatment and control of tuberculosis.

(3) Preventing and controlling the spread of tuberculosis in interstate traffic, and any other activities with respect to the prevention, treatment and control of tuberculosis that may be authorized to be performed by the Public Health Service.

The Journal is advised that the Public Health Service will limit its participation to the state level and that all activities at a lower level will be conducted through the State Health Department. Prior to establishment of any measures within the state, a survey will be made and opinions of the medical profession and of health officers will be obtained with a view to giving the state the greatest possible assistance in the fields where assistance is most needed. No program for the building and maintenance of sanatoria, or for their extension, is at present contemplated. While mass chest surveys will be continued, the present program does not aim to secure a chest X-ray of the entire population. Mass chest surveys will continue in much the same manner as now but probably with an increase in facilities.

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*Rust, M. E.	Harrison
*Thompson, James I.	Yellville
Watkins, W. L.	Alpena Pass

BRADLEY COUNTY

Belcher, Charles D.	USN
Crow, Marvin B.	USA
Crow, Marvin T.	Warren
Crow, Merle T.	USA
†Gannaway, C. E.	Warren
*Hunt, W. J.	Warren
†Martin, Charles	Warren
Martin, Rufus	Warren
Reasons, W. B.	Hermitage
Roark, W. N.	Hermitage

CARROLL COUNTY

Bohannon, J. H.	Berryville
Butt, W. A.	Green Forest
*Carier, A. L.	Berryville
Donaldson, C. W.	Green Forest
John, J. F.	Eureka Springs
*McCurry, D. K.	Green Forest
Newkirk, W. H.	USA

† Deceased.

* Wife is Auxiliary member.

The Roster of the Arkansas Medical Society has been placed in the center of this issue to permit its ready removal for filing.

Roberts, D. C.	Berryville
Webb, J. H.	Eureka Springs

CHICOT COUNTY

Baker, E. E.	Dermott
*Barlow, B. E.	Dermott
*Barlow, E. E.	Dermott
*Bottorff, M. K.	Lake Village
Burge, J. H.	Lake Village
Clark, B. C.	Lake Village
Craig, W. A.	Eudora
Douglas, S. W.	Eudora
Easterling, Walter D.	USA
*Leverett, Chas. G.	USA
McGehee, E. P.	Lake Village
*Thompson, J. A.	Dermott

CLARK COUNTY

Barnett, J. R.	Arkadelphia
Bremer, J. P.	Point Cedar
Bryant, R. L.	Arkadelphia
McLain, J. T.	Gurdon
Norton, J. M.	Arkadelphia
Pate, J. N.	Arkadelphia
Reid, Joe W.	Arkadelphia
Townsend, Chas. K.	Arkadelphia

CLAY COUNTY

Blackwood, W. J.	Rector
Clopton, O. H.	Rector
Futrell, J. B.	USA
Hiller, J. P.	Pollard
Jones, F. H.	Piggott
Latimer, N. J.	Corning
McGuire, J. E.	Piggott
Turner, W. E.	USA
Turner, W. E., Sr.	Piggott

COLUMBIA COUNTY

Brandon, C. W.	Emerson
Baker, J. J.	Magnolia
Carrington, H. K.	USA
Cooksey, W. P.	Magnolia
Horn, W. H.	Magnolia
Jones, T. H.	Waldo
Jordan, T. S.	Magnolia
Kitchens, H. M.	Waldo
Longino, L. A.	Magnolia
McLeod, G. F.	Magnolia
Rushton, J. F.	Magnolia
Smith, P. M.	Magnolia
Souter, A. J.	Waldo
Souter, T. E.	McNeil
Weber, Chas. L.	USA
Wilson, J. H.	Magnolia

CONWAY COUNTY

Close, Edgar	Jerusalem
Etheridge, C. E.	Morrilton
Halbrook, J. F.	Plumerville
Hardison, T. W.	Morrilton
Mobley, H. E.	Morrilton
Jones, R. A.	Perry
Williams, C. R.	USA

CRAIGHEAD-POINSETT COUNTY

Alcott, Geo. B.	Weiner
Barrett, E. R.	USN
Berry, W. E.	USA
*Blanton, M. E.	USA
Burge, H. G.	Nettleton
†Cantrell, M. L.	Marked Tree
*Cohen, O. T.	Jonesboro
Dickerson, D. A.	Marked Tree
*Ellis, Ira W.	Monette
Faris, John C.	USA
Harris, Chas. P.	USA
Hartwig, C. D.	Lake City
Horner, E. J.	Jonesboro
Jones, J. H.	Lepanto
*Jones, J. K.	Lepanto
Ledbetter, Jos. W.	Jonesboro
*Lutterloh, P. W.	Jonesboro
*McAdams, H. H.	Jonesboro
McCurry, J. H.	Cash
*McDaniel, E. C.	Tyrnza
McDaniel, L. H.	Tyrnza
*Modelevsky, A. C.	Jonesboro

Moreland, W. H.	Tyrnza
Nisbett, Frank	Brookland
Overstreet, W. C.	Jonesboro
Pierce, J. O.	USA
Ramsey, J. W.	Jonesboro
Reagan, C. H.	USA
Shanlever, R. C.	Jonesboro
*Sloan, Ralph M.	Jonesboro
Smith, O. V.	Trumann
Smith, W. H.	Bono
*Stroud, E. J.	Jonesboro
*Stroud, H. A.	Jonesboro
*Stroud, P. T.	USA
Thorn, W. T.	Marked Tree
Tullos, A. M.	Trumann
Verser, Joe	USA
*Verser, W. W.	Harrisboro
*Willett, R. H.	Jonesboro

CRAWFORD COUNTY

Bennett, B. L.	Van Buren
*Bruce, B. B.	Alma
Boomer, F. A.	Van Buren
Campbell, C. J.	Mulberry
Crigler, R. J.	Alma
Dixon, Chas. B.	Van Buren
Galloway, O. R.	Alma
Grant, S. C.	Mulberry
Kirkland, S. D.	Van Buren
Kirkland, S. S.	USA
Kirksey, O. J.	Mulberry
Porter, James O.	Okla. City, Okla.
Savery, H. W.	Van Buren

CRITTENDEN COUNTY

Bond, S. D., Jr.	USN
*Hare, T. S.	Crawfordsville
*Hamilton, Ralph B.	West Memphis
Irby, J. T.	Earle
*Matthews, J. H.	Earle
McVay, L. C.	Marion
*Parker, A. C., Sr.	Clarksdale
Parker, A. C., Jr.	USA
Purnell, R. L.	Marion
*Ray, Robert H.	Earle
*Stevenson, B. M.	West Memphis
*Watson, H. S.	Earle

CROSS COUNTY

Barr, A. F.	Cherry Valley
Griffin, W. L.	Cherry Valley
Hickman, R. L.	Hickory Ridge
Longest, Ruffin	Wynne
Miller, J. S.	Wynne
Peterson, T. A.	Wynne
Price, Thomas G.	USN
Smith, R. S.	Parkin
Wilson, Thomas	Wynne

DALLAS COUNTY

Estes, E. E.	Fordyce
Estes, S. J.	Fordyce
Lisenbee, A. M.	Sparkman
Taylor, J. E. M.	Sparkman
Ward, W. P.	USA

DESHA COUNTY

*Biscoe, Gibbs	Dumas
Hellums, J. H.	USA
Kimbro, C. H.	Tillar
*Leverett, Marion	McGehee
McCammion, Vernon	Arkansas City
*Rands, H. A.	Dumas
*Smith, H. T.	McGehee
*White, R. F.	McGehee

DREW COUNTY

*Billingsley, Lindsey F.	Monticello
Binns, B. Z.	USA
Collins, A. S. J.	Monticello
Dickens, Robt. D.	USA
Gates, Stanley M.	USA
Holder, J. B.	USA
Pope, M. Y.	Monticello
*Price, J. P., Jr.	Monticello
*Wilson, J. S.	Monticello

FAULKNER COUNTY

Archer, C. C.	Conway
Baldrige, Doris A.	Vero Beach, Fla.
Baldrige, Max	USN
Brittain, W. L.	Conway
Brooke, H. C.	USA
Clark, A. S. J.	Conway
Dawson, R. L.	Bee Branch
Dickerson, C. H.	Conway
Downs, J. H.	Vilonia
Dunaway, E. L.	USA
Dunaway, L. S.	Conway
Fraser, N. E.	Conway
Glover, A. J.	Guy
Harrod, George	Conway

Henderson, G. L.	Conway
Ingram, E. M.	Enola
Kitley, J. R.	Mayflower
Lieblong, J. S.	Greenbrier
Mabry, Tom	Vilonia
McCollum, I. N.	Conway
Taylor, R. L.	USA
Williams, E. T.	Greenbrier

FRANKLIN COUNTY

Bollinger, W. H.	Charleston
*Gibbons, W. H.	Ozark
Jewell, I. H.	Paris
*Pillstrom, E. W.	Ozark
*Porter, W. C.	Ozark

GARLAND COUNTY

*Adams, Frank M.	USA
Bieri, E. J.	USA
Black, T. N.	Hot Springs
*Blackshare, W. M.	Hot Springs
*Bollmeier, L. N.	Hot Springs
Bowman, M. B.	USA
Boydstone, J. O.	USA
Brewer, Howell	USA
Browning, E. R.	Hot Springs
Buckelew, H. H.	USA
Burch, N. B.	Hot Springs
Burton, F. M.	USA
Casada, B. F.	Hot Springs
Chamberlain, W. W.	USA
*Chestnutt, J. H.	Hot Springs
Clardy, Floyd	Hot Springs
Coffey, G. C.	Hot Springs
Connell, W. H.	Hot Springs
Diederich, V. P.	Hot Springs
*Ellis, Jack R.	USA
*Fletcher, Geo. B.	Hot Springs
Garratt, C. E.	Hot Springs
*Gray, W. E.	Hot Springs
*Hebert, Gaston A.	USN
Jarrell, Foster	Hot Springs
*King, O. H.	Hot Springs
Klugh, W. G.	Hot Springs
*Lee, D. C.	Hot Springs
*Lutterloh, C. H.	USA
Martin, L. G.	Hot Springs
McKenzie, E. M.	Hot Springs
Moss, C. S.	Hot Springs
Nims, C. H.	Hot Springs
Pate, C. N.	Hot Springs
Porter, W. F.	Hot Springs
*Power, A. R.	Hot Springs
Proctor, J. M.	Hot Springs
*Purdum, E. A.	Hot Springs
*Reed, L. E.	Hot Springs
*Rowland, Driver	USA
Rowland, J. F.	Hot Springs
Scott, Jeff O.	USA
Scully, F. J.	Hot Springs
Shaw, E. I.	Hot Springs
Shebesta, Bessey H.	Hot Springs
Short, Z. N.	Hot Springs
Smallwood, R. E.	USA
*Smith, E. M.	USA
*Smith, O. A.	Hot Springs
*Smith, W. K.	Hot Springs
*Stell, J. S.	Hot Springs
Stough, D. B.	Hot Springs
Strachan, J. B.	Hot Springs
Sullivan, A. G.	USN
*Tarleton, F. S.	Hot Springs
*Tribble, A. H.	Hot Springs
*Thompson, E. L.	Hot Springs
Ulferts, U. R.	USA
*Wade, H. K.	Hot Springs
*Weil, S. D.	Hot Springs
Wilkins, J. S.	Hot Springs
*Wootton, W. T.	Hot Springs
*Wright, H. K.	Hot Springs

GRANT COUNTY

Cole, C. F.	Prattsville
Cole, John W.	Sheridan
Hope, O. W.	Sheridan
Kelly, M. F.	Sheridan
Kelly, O. R.	Sheridan
Kelly, R. M.	USA

GREENE COUNTY

Blackwood, J. D.	Jonesboro
Bridges, G. P.	Paragould
Dillman, J. A.	Paragould
Ellington, W. E.	Paragould
Haley, R. J., Jr.	Paragould
Hudgins, J. J.	Paragould
Hutcherson, R. L.	Delaplaine
Lamb, J. W.	USA
Lamb, W. M.	Paragould
McKelvey, Earle	Paragould

HEMPSTEAD COUNTY

*Allison, W. G.	Hope
Branch, J. W.	USA
Cannon, G. E.	Hope
Carrigan, P. B.	Hope
Gentry, J. E.	McCaskill
Heller, H. G.	Hope
Holt, H. H.	USA
*Lile, L. M.	Hope
*Martindale, J. G.	USA
*McKenzie, Jim	USA
Robins, W. F.	Ozan
*Smith, Don	Hope

HOT SPRING COUNTY

*Barrier, W. F.	Malvern
*Brown, H. L.	Malvern
Hodges, T. L.	Bismarck
*Hodges, W. G.	Malvern
McCray, E. H.	Malvern
*McCray, R. V.	Malvern
*Pool, C. S.	Malvern
*Prickett, M. D.	Iowa City, Iowa

HOWARD-PIKE COUNTY

Alford, T. F.	Murfreesboro
Burleson, J. J.	Antione
Dildy, E. V., Sr.	Nashville
Dildy, E. V., Jr.	Mineral Springs
Duncan, M. D.	Murfreesboro
Gould, W. B.	Glenwood
Hopkins, J. S.	Nashville
Roberts, J. L.	Nashville
Simpson, W. B.	Nashville
Toland, Wm. H.	Nashville
Waldrop, J. G.	Nashville

INDEPENDENCE COUNTY

Barger, O. B.	USA
Barnett, J. C.	USA
*Bone, O. L.	Newark
Brown, H. H.	Crossett
*Calaway, W. H.	USA
Chambers, S. W.	Mountain Home
*Churchill, C. A.	USA
Copp, Noel	Calico Rock
*Craig, M. S.	Batesville
*Evans, L. T.	Batesville
Gray, E. M.	Mountain Home
Gray, W. Paul	Batesville
*Hinkle, C. G.	Batesville
*Jeffery, Paul	Bethesda
*Johnston, O. J. T.	Batesville
*Ketz, W. J.	Batesville
Matthews, J. T.	Heber Springs
*McAdams, V. D.	Cord
*Monfort, J. J.	USA
Robertson, S. N.	Sulphur Rock
Roe, C. E.	Viola
Weddington, R. E.	USA
Wood, O. S.	Salem
*Wyatt, F. Q.	Batesville

JACKSON COUNTY

*Best, A. L.	Newport
Elton, A. M.	Newport
Erwin, Ira H.	Newport
Gray, C. R.	Newport
Harris, M. L.	Newport
Ivy, J. B.	Tuckerman
Jamison, O. A.	Tuckerman
Kimberlin, K. K.	Tuckerman
Norris, R. O.	Tuckerman
Walker, H. O.	Newport
†Watson, E. L.	Newport

JEFFERSON COUNTY

*Beard, J. C.	Booneville
Binns, Van C.	USA
*Bruce, W. H.	Pine Bluff
Capel, C. B.	Pine Bluff
*Capel, H. T.	USA
Carruthers, C. K.	Pine Bluff
*Causey, H. A.	USA
*Clark, O. W.	Pine Bluff
*Cunningham, T. J., Jr.	Pine Bluff
Cunningham, T. J., Sr.	Pine Bluff
Garratt, A. A.	Pine Bluff
Gurney, John O.	Pine Bluff
*Hames, Fred	Pine Bluff
Hancock, W. G.	Rison
Higinbotham, C. J.	Pine Bluff
Jenkins, J. S.	Pine Bluff
*Lowe, W. T.	Pine Bluff
Luck, B. D., Jr.	Pine Bluff
Luck, B. D., Sr.	Pine Bluff
*Maynard, R. E.	USA
*McMullen, E. C.	Pine Bluff
Palmer, J. T.	Pine Bluff
*Payne, Virgil	Pine Bluff
Reid, Chas. W.	Pine Bluff

Robertson, A. B.	Rison
Russell, A. R.	USA
Shelton, M. A.	Wabbaseka
Simmons, Walter H.	Pine Bluff
*Spillyards, J. S.	Pine Bluff
*Walker, John K.	Pine Bluff
Woods, R. P.	Alzheimer

JOHNSON COUNTY

Floyd, John	Ozark
Graves, S. M.	Clarksville
*Hardgrave, Geo. L.	Clarksville
*Hunt, Earle H.	Clarksville
*Johnston, R. H.	USA
*Kolb, J. M.	USA
Pierce, S. C.	Lamar
*Shrigley, Guy P.	USA
*Siegel, G. R.	Clarksville

LAFAYETTE COUNTY

Armstrong, R. L.	Lewisville
Baker, F. E.	Stamps
Keith, A. W.	Stamps
McKnight, J. F.	Bradley

LAWRENCE COUNTY

Ball, C. C.	Ravenden
Blaine, Mitchell	Mammoth Springs
Brown, W. W.	Hardy
Cruse, E. J.	Black Rock
Elders, J. B.	USA
Guthrie, T. C.	Smithville
Faircloth, Robert S.	Walnut Ridge
Hatcher, W. W.	Imboden
Henderson, A. G.	Imboden
Hughes, Max	USA
Hull, H. B.	Mammoth Springs
Jackson, J. F.	USA
Johnson, T. Z.	Walnut Ridge
Kendall, W. S.	Cave City
Land, J. C.	Walnut Ridge
†Merrell, J. L.	Walnut Ridge
Tibbels, C. C.	Black Rock
Townsend, C. C.	Walnut Ridge

LEE COUNTY

Bogart, H. D.	Marianna
Chaffin, C. W.	Moro
Crawford, W. S.	Marianna
Hamner, J. H.	Aubrey
Hodge, N. C.	Marianna
McClendon, Mac	Marianna

LINCOLN COUNTY

Bailey, B. L.	Sterlington, La.
*Dixon, C. W.	Gould
*Gardner, B. M.	Star City
Taylor, L. T.	USA
Thiolliere, A. C.	North Little Rock
Wood, G. C.	Grady

LITTLE RIVER COUNTY

Harding, C. A.	Ashdown
Peacock, Norman W.	Ashdown
Yates, E. W.	Foreman

LONOKE COUNTY

Beaty, S. S.	England
Brewer, J. T.	Kerrs
*Callahan, E. A.	Carlisle
Corn, F. A.	Lonoke
Crowgey, W. B.	Scott
Southall, S. A.	Lonoke
Ward, O. D.	England
Watson, A. C.	Benton
Wells, J. B.	Scott
Whaley, E. S.	Carlisle

MILLER COUNTY

Abrams, H. K.	Atlanta, Ga.
Boone, R. F.	Texarkana
Burnett, J. W.	USA
*Daniel, N. B.	Texarkana
*Daubs, W. H.	Foreman
Frank, C. H.	Texarkana
Fuller, T. E.	Texarkana
Good, L. P.	Texarkana
*Hibbitts, Wm.	Texarkana
Hunt, Preston	Texarkana
*Kemp, K. H.	USA
*Kirkpatrick, R. R.	Texarkana
*Kittrell, T. F.	Texarkana
*Kosminsky, L. J.	Texarkana
*Lanier, L. H.	Texarkana
*Lee, A. G.	Texarkana
Lennard, F. M.	Texarkana
Middleton, B. D.	Texarkana
*Murry, H. E.	Texarkana
Parson, G. W.	Texarkana
Porter, J. T.	USA

Robins, R. R.	Texarkana	Fink, M.	Helena	*Crawford, J. B.	Little Rock
*Smith, W. D.	Texarkana	Johnston, W. W.	USA	Cullen, P. T.	USA
*Tate, J. B.	Texarkana	King, Jack	USA	*Cummins, Bryce	Little Rock
Williams, J. F.	Texarkana	†King, J. A.	Elaine	*Cunningham, J. C.	Little Rock
MADISON COUNTY					
Counts, G. D.	Wesley	King, J. W.	USA	Darby, Wm. J.	North Little Rock
Martin, C. J.	Hindsville	King, W. C.	Helena	Darnall, R. F.	Little Rock
Youngblood, Fred	Huntsville	Kultgen, Edward	Elaine	Davis, J. C.	Little Rock
MISSISSIPPI COUNTY					
Atkinson, G. S.	Blytheville	Maddox, A. H.	USA	*Day, E. O.	Little Rock
Beasley, J. E.	USN	Moore, J. C.	Dyersburg, Tenn.	*Dean, G. O.	USN
Boyd, D. L.	Blytheville	Nicholls, J. W.	Helena	Dibrell, J. L.	Little Rock
Brownson, J. F.	Blytheville	Norton, E. F.	Marvell	Dibrell, J. R.	Little Rock
Budd, E. C.	Blytheville	Orr, W. R.	Helena	Dishongh, H. A.	Little Rock
Campbell, J. H.	Marvell	Rightor, H. H.	Helena	*Donaldson, J. K.	USA
Dorman, J. W.	USA	Ritchie, J. L.	Helena	*Dykstra, D. W.	U.S.P.H.S.
Ellis, N. B.	Wilson	Russwurm, W. C.	Helena	*Easley, E. J.	Little Rock
Harwell, C. M.	Osceola	†Storm, Geo. R.	West Helena	*Eaton, John P.	USA
Hassell, L. L.	USA	POLK COUNTY			
Hosey, N. R.	Marvell	Campbell, C. A.	Mena	*Eschweiler, Paul C.	Little Rock
Hollingsworth, G. F.	Dyess	Hawkins, B. H.	Mena	*Eubanks, R. M.	Little Rock
Hubener, L. L.	Blytheville	Lee, F. A.	Vandervoort	Fatherree, L. L.	Little Rock
Hudson, T. F.	Luxora	McElroy, F. Q.	Mena	Ferguson, R. L.	Baltimore, Md.
Husband, F. L.	Blytheville	*Miers, E. M.	Mena	Fletcher, Elizabeth	Little Rock
Johnson, I. R.	Blytheville	Norwood, Frank A.	Mena	Fowler, H. D.	USA
Johnson, R. L.	Bassett	*Redman, Pierre	Mena	Freedman, Theo.	Little Rock
Mahan, T. K.	USA	POPE-YELL COUNTY			
Massey, L. D.	USA	Ballenger, W. E.	Plainview	Fuller, H. L.	USA
Moseley, K. T.	USA	Cowan, Riley	Van Buren	*Fulmer, D. W.	USA
Owen, W. M.	Armored	Gardner, Ellis	Russellville	*Fulmer, P. M.	Little Rock
Polk, J. T.	Keiser	Gardner, L.	Russellville	Fulmer, S. C.	Little Rock
Robinson, A. F.	Leachville	Gilliam, A. D.	Belleville	*Gay, E. C.	USA
Robinson, H. D.	Manila	Grace, Kent	USA	Gerber, W. F.	Little Rock
Saliba, J. A.	Blytheville	Griffin, E. P.	USA	Gordon, Vida	Little Rock
Sheddan, W. J.	Osceola	Hood, Robert	Russellville	*Gray, A. F.	Little Rock
Sims, H. C.	USA	Hunt, E. C.	Ola	*Gray, Oscar	Little Rock
Skaller, M. L.	Blytheville	Millard, Roy I.	Russellville	Grayson, W. B.	Little Rock
Stevens, C. C.	Blytheville	Montgomery, H. L.	Gravelly	Greutter, J. E.	USA
Turrentine, P. W.	Osceola	Moore, J. H.	Delaware	*Hardeman, D. R.	USA
Walls, J. M.	USA	Rushing, F. E.	Hot Springs	Harrell, W. B.	USA
Webb, Floyd	Blytheville	Sexton, J. W.	Dover	Harris, F. W.	Little Rock
Wilson, C. E.	Blytheville	Smith, L. M.	Russellville	Harris, Robert P.	Sarasota, Fla.
MONROE COUNTY		Smith, R. L.	Russellville	*Hayes, J. D.	USA
Boswell, W. L.	Clarendon	Stanford, J. M.	Russellville	*Hayes, J. H.	Little Rock
Bradley, W. T.	Blackton	Tate, A. B., Sr.	Russellville	*Henry, C. R.	Little Rock
*Dalton, M. L.	Brinkley	Teeter, Brooks R.	USA	Herron, John T.	Little Rock
Martin, W. H.	Holly Grove	Young, W. O., Jr.	Russellville	*Higgins, H. A.	USA
*McKnight, C. H.	Brinkley	PRAIRIE COUNTY			
*McKnight, E. D.	Brinkley	Adams, Edward	DeValls Bluff	Hill, Harlan H.	USA
MONTGOMERY COUNTY		Calley, J. H.	USA	*Hollenberg, H. G.	USA
Freeman, W. D.	Mt. Ida	Crockett, W. H.	Biscoe	*Hollis, N. T.	Little Rock
McLean, J. H.	Caddo Gap	Gilliam, J. C.	Des Arc	Holmes, G. M.	Little Rock
Stueart, J. B.	Norman	Lynn, J. R.	Hazen	Holmes, H. C.	Little Rock
Watkins, G. E.	Mt. Ida	Parker, W. M.	USA	Holt, L. G.	USA
NEVADA COUNTY		Porter, T. G.	Hazen	Hoover, P. W.	USA
*Buchanan, A. S.	Prescott	PULASKI COUNTY			
Cox, J. E.	Rosston	*Aday, J. Leo	USA	Hundley, John M.	USN
Hairston, G. G.	USA	Agar, John S.	USN	*Hundling, H. W.	Little Rock
*Hesterly, J. B.	Prescott	Alford, T. Dale	USA	Hyatt, C. L.	USA
*Hirst, O. B.	USA	*Allen, H. R.	Little Rock	*Hyatt, D. T.	Little Rock
*Kennedy, J. W.	USA	Atkinson, Shelby	North Little Rock	Hyatt, R. F.	USA
*McDaniel, T. W.	Boughton	Anderson, C. C.	Little Rock	Jackson, Robert H.	Little Rock
Pool, W. B. H.	Bodcaw	Anderson, P. R.	USA	*Johnson, Glen H.	Little Rock
*Rouse, B. H.	Prescott	*Arkebauer, C.	Little Rock	*Jones, H. Fay H.	Little Rock
OUACHITA COUNTY		*Armstrong, H. M.	USA	Jones, J. E.	Little Rock
*Byrd, E. J.	Camden	*Askew, J. B.	Reno, Nev.	Junkin, Ruth H.	Pine Bluff
*Clemens, J. P.	Stephens	*Autry, D. H.	USA	Junkin, S. P.	Little Rock
Dalton, Perry	USN	*Autry, P. G.	Little Rock	Kilbury, M. J.	Little Rock
*Early, C. S.	Camden	Banks, Jeff	Little Rock	Kober, W. M.	USA
*Jameson, J. B.	Camden	*Barrier, L. F.	Little Rock	Kolb, A. C.	Little Rock
*Kennerly, R. C.	Camden	*Bennett, B. A.	USA	Kolb, Agnes C.	Little Rock
*Magness, W. C.	USA	*Bizzell, Ross	USA	Kolb, B. T.	Little Rock
*McGill, S. D.	Camden	*Blakely, R. M.	Little Rock	*Kory, R. C.	Little Rock
*Partee, N. G.	Camden	*Blankfort, Gerald	USA	*Lamb, W. A.	Little Rock
Plunkett, C. M.	Elliott	*Boyle, R. M.	Little Rock	*Langston, W. C.	Little Rock
*Powell, B. V.	Camden	*Briggs, B. P.	USA	*Law, R. A.	Little Rock
*Rhine, T. E.	Thornfon	*Brooks, C. M.	Little Rock	*Lawson, Mason	Little Rock
*Rhinehart, J. S.	Camden	Brown, Martha M.	Little Rock	Levy, J. S.	USA
*Robins, R. B.	Camden	*Brown, T. D.	USA	Lewandoski, Martha S.	Little Rock
*Robins, R. R.	Camden	Burgess, T. E.	Little Rock	Lewis, G. V.	Little Rock
Rushing, J. L.	Chidester	Burns, W. M.	Little Rock	Lyons, V. E.	USA
Thompson, H. F.	Bearden	Byrd, L. M.	USA	Mahoney, P. L.	Little Rock
*Thompson, S. A.	Camden	Calcote, R. J.	USN	*Martin, A. B.	USA
Thompson, S. B.	USA	Caldwell, Robert	Little Rock	*May, C. B.	Little Rock
PHILLIPS COUNTY		Carruthers, F. W.	Little Rock	Mazzanti, Vincent	USA
Baker, J. P.	West Helena	Cazort, Alan G.	Little Rock	*McCaskill, M. E.	Little Rock
Blackwood, J. O.	USA	Champion, J. P.	USA	McCaskill, M. R.	Little Rock
Butt, J. W.	Helena	Cheairs, D. T.	Little Rock	McClain, M. D.	USA
Connolly, W. B.	USA	Chesnutt, C. R.	Little Rock	*McLochlin, R. E.	USA
Cox, A. E.	Helena	*Choate, H. L.	Little Rock	*McMillan, Lamar	Little Rock
Cox, A. W.	Helena	*Church, B. L.	North Little Rock	McRae, W. M.	Little Rock
Dozier, F. S.	USA	Clark, A. C.	Little Rock	*Means, Ben D.	Little Rock
Ellis, J. B., Sr.	Helena	*Compton, J. N.	Little Rock	Melson, Madeline	Little Rock
Ellis, W. A.	Helena	Coon, A. B.	Little Rock	Melson, O. C.	Little Rock
		Cook, R. C.	USN	Moore, R. D.	USA
		Cooper, Wm. G.	Little Rock	Morgan, Vern E.	Little Rock
		*Cope, E. P.	USA	Morgans, Dollie	USA
		*Cosgrove, K. W.	Little Rock	*Morris, H. J.	Little Rock
				*Murphey, Pat	Little Rock
				*Newman, W. V.	Little Rock
				Nisbett, J. M.	USA
				Nixon, Ewing	USA
				Nowlin, W. A.	Roland
				*Oates, Chas. E.	North Little Rock
				*Parsons, J. E.	Little Rock
				Parsons, W. R.	USA

Patterson, R. Q.	Little Rock
Peters, Leo E.	Little Rock
Phillips, Bert L.	Little Rock
Phillips, Sam	USA
Phipps, W. E.	USA
*Raley, B. V.	USN
Raney, T. J.	USA
*Reagan, G. W.	Little Rock
*Reagan, L. D.	Little Rock
*Reaves, B. J., Jr.	Little Rock
*Reed, C. C., Jr.	USA
*Reed, C. C., Sr.	Little Rock
*Rhinehart, B. A.	Little Rock
*Rhinehart, D. A.	Little Rock
*Rhyne, J. T.	Little Rock
*Richardson, W. R.	Little Rock
*Riegler, N. W.	Little Rock
Riggins, W. C.	USA
Ritchey, Lloyd F.	USA
Ritchie, E. J.	USA
*Roberts, J. N.	USA
*Robinson, B. L.	Little Rock
*Rodgers, Clyde D.	USA
*Rosenbaum, Carl A.	Little Rock
Ross, T. T.	Little Rock
*Rowland, R. E.	Little Rock
Ruff, Horace E.	Little Rock
*Sadler, W. L.	Little Rock
*Samuel, John	USA
*Sanderlin, J. H.	USA
Sanford, S. M.	USA
Savage, H. W.	USA
Saxon, R. L.	Little Rock
*Schwarz, W. J.	Little Rock
*Shipp, A. C.	Little Rock
*Shipp, Harvey	USN
*Shuffield, J. F.	Little Rock
*Shukers, C. F.	USA
Slaughter, Pauline K.	Little Rock
Smith, H. H.	USA
*Smith, J. W.	USA
*Smith, R. T.	Little Rock
*Smith, W. M.	USA
*Sparks, A. R.	Little Rock
*Spitzberg, Irving J.	Little Rock
Statnakis, John	Lincoln, Neb.
*Stern, Howard S.	Little Rock
Stenkamp, G. R.	USA
Stover, A. R.	Holbrook, Ariz.
*Strauss, A. W., Sr.	Little Rock
Strauss, A. W., Jr.	USA
*Summers, J. A.	Little Rock
*Switzer, D. W.	North Little Rock
Thomas, P. E.	Little Rock
*Thompson, E. I.	Little Rock
Thompson, G. D.	Little Rock
*Thompson, Robert L.	Little Rock
Turnbow, R. L.	USA
*Wallis, Charles	Little Rock
*Warden, J. R.	Little Rock
Washburn, A. M.	USA
Watkins, John G.	Little Rock
Warford, Walton R.	Little Rock
Watson, Asa C., Jr.	USA
*Watson, C. F.	Little Rock
Watson, C. Robert	Little Rock
*Wayman, A. K.	Little Rock
*Wayne, J. R.	Little Rock
*Webb, V. T.	Little Rock
*Weny, N. F.	Little Rock
*Whittier, R. W.	Little Rock
*Wickard, C. P.	USA
Wilcox, L. A.	Little Rock
*Wilkes, E. Hays	USA
*Young, R. G.	USA

RANDOLPH COUNTY

Baltz, M. A.	Pocahontas
Brown, J. W.	Pocahontas
Finney, C.	Maynard
Hamil, W. E.	Pocahontas
Loftis, J. R.	Pocahontas
Loftis, W. O.	USA
Ryburn, J. W.	Pocahontas
Smith, J. E.	Reyno
Smith, R. O.	Biggers

ST. FRANCIS COUNTY

Bogart, C. N.	USA
Burch, W. D.	Hughes
Caldwell, A. B.	Forrest City
Chaffin, E. J.	Hughes
Davis, Luther	Tucson, Ariz.
Davidson, J. S.	Forrest City
Lanier, Paul S.	Hot Springs
McClendon, H. L.	Palestine
McCowan, N. C.	Forrest City
Mohler, D. A.	Brinkley
Roy, J. M.	Forrest City
Rush, J. O.	Forrest City

SALINE COUNTY

Ashby, John	Benton
Blakely, M. M.	Benton
Buffington, T. E.	Benton
Boen, L. R.	Bauxite
Ellis, W. S.	Bauxite
Gann, Dewell, Sr.	Benton
Gann, Dewell, Jr.	Benton
Harrell, L. J.	Bauxite
Harris, Thomas S.	Springfield, Mo.
*Jones, C. W.	Benton
Ward, W. W.	Alexander
Walton, Chas. R.	Gulfport, Miss.

SEARCY COUNTY

*Bing, E. A.	Marshall
Cotton, J. O.	Leslie
Daniel, S. G.	Marshall
Evans, P. L.	Marshall
Fendley, E. G.	Leslie
Hall, H. J.	Clinton
Leslie, J. O.	Marshall
Moore, W. T.	Marshall
Rogers, W. F.	St. Joe

SEBASTIAN COUNTY

*Adams, W. F.	Fort Smith
Amis, J. W.	USN
Arnold, W. O.	Temple, Tex.
Benefield, C. E.	Fort Smith
Benefield, J. H.	Fort Smith
Billingsley, C. B.	Fort Smith
*Blair, A. A.	Fort Smith
*Brooksher, W. R.	Fort Smith
*Chamberlain, C. T.	Fort Smith
Coffman, J. S.	Lavaca
*Crigler, R. E.	Fort Smith
Curtis, A. C.	Little Rock
Dickey, A. B.	State Sanatorium
*Dorsey, H. C.	Fort Smith
*Eberle, W. G.	Fort Smith
Even, Martin M.	Fort Smith
Finney, C. H.	USA
*Foltz, T. P.	USN
*Foster, M. E.	Fort Smith
*Goldstein, D. W.	Fort Smith
*Hall, C. W.	Greenwood
Henry, C. A.	State Sanatorium
Henry, Louise	Fort Smith
Henry, L. M.	USA
Hedrick, Rogers	USA
*Hoge, A. F.	Fort Smith
*Holt, C. S.	Fort Smith
Holt, Ernest E.	Temple, Texas
Johnson, Hugh	Fort Smith
Johnson, J. D.	USA
Johnson, J. E.	Fort Smith
*Jones, I. F.	Fort Smith
Jones, E. B.	Hartford
*Kellum, J. L.	Bogalusa, La.
Kennedy, C. H.	Fort Smith
*Krock, F. H.	USN
Little, J. E.	Wildcat Sanatorium
*McConnell, S. P.	Booneville
*Moulton, E. C.	Fort Smith
Moulton, H.	Fort Smith
Nowlin, R. R.	State Sanatorium
Pride, Ben H.	USA
Redman, J. W.	Fort Smith
*Riley, J. D.	State Sanatorium
*Rose, W. F.	Fort Smith
*Schirmer, R. E.	USA
*Scott, M. H.	Fort Smith
Shippey, W. L.	Fort Smith
*Southard, J. S.	Fort Smith
*Stevenson, J. E.	Fort Smith
Stocker, G. F.	USN
*Stubbs, S. P.	Fort Smith
Thompson, H. B.	Fort Smith
*Thompson, J. K.	USA
*Smith, H. H.	Fort Smith
Waddell, Pearl B.	Fort Smith
*Ware, B. L.	Fort Smith
*Wilson, C. L.	USA
*Wolferman, S. J.	Fort Smith
*Woods, G. G.	Huntington
*Woods, W. M.	USA

SEVIER COUNTY

*Archer, C. A.	DeQueen
Dean, Lee Andrew	DeQueen
*Dickinson, R. C.	Horatio
*Hanchey, C. C.	USA
*Hendricks, J. S.	DeQueen
*Hopkins, R. L.	DeQueen
*Jones, I. G.	DeQueen
*Kimball, G. L.	USA
*Kitchens, C. E.	DeQueen
Norwood, M. L.	Lockesburg

UNION COUNTY

Atkinson, O. L.	Hampton
*Cathey, A. D.	El Dorado
Cullins, J. G.	American Lake, Wash.
Cox, Vincent M.	USA
*Fincher, L. G.	El Dorado
*Harper, J. W.	USN
Irby, F. L.	El Dorado
Jones, Gus W., Jr.	USA
Jones, Kenneth G.	USN
Kennedy, C. E.	Smackover
Kitchens, D. K.	Detroit, Mich.
*Levine, David	El Dorado
*Mahony, F. O.	El Dorado
*Mayfield, H. F.	Huttig
Mayfield, H. J.	USA
McCall, Daniel	Lawson
*McGraw, S. J.	El Dorado
*Mitchell, J. G.	El Dorado
*Moore, B. L.	El Dorado
*Munn, E. J.	El Dorado
*Murphy, G. D., Jr.	USA
*Murphy, G. D., Sr.	El Dorado
*Murphy, N. A.	El Dorado
*Muse, P. H.	Junction City
*Newton, W. L.	Smackover
Patton, Doyle	USA
Pinson, J. H.	USA
Poole, Belle D.	Pasadena, Calif.
*Riley, W. S.	USA
*Russell, M. V.	El Dorado
*Sheppard, J. K.	USN
Slaughter, J. W.	El Dorado
*Snodgrass, Wm. A.	Little Rock
Wharton, J. B.	USN
*Wharton, J. B., Sr.	El Dorado
*White, D. E.	El Dorado

WASHINGTON COUNTY

Alexander, Gilbert	Muskogee, Okla.
*Baggett, Jeff.	Prairie Grove
Bean, J. L.	Lincoln
Bunch, W. L.	U.S.P.H.S.
*Butt, W. J.	USA
Callen, C. B.	Fayetteville
*Compton, Neil	USN
DeLaney, Jos. E.	Fayetteville
*Ellis, E. F.	Fayetteville
Fowler, W. A.	Fayetteville
Gilbert, A. A.	Fayetteville
*Hathcock, Alfred	USA
*Hathcock, Preston	Fayetteville
*Hathcock, P. L.	Fayetteville
*Huntington, R. H.	Fayetteville
Hoot, Melvin P.	Fayetteville
Hundley, Louis K.	USA
Leming, Howell E.	Fayetteville
Lesh, Ruth Ellis	Fayetteville
Lesh, V. O.	USA
*Lewis, James F.	USN
*Miller, R. W.	USA
Mock, W. H.	Prairie Grove
*Paddock, C. S.	USN
*Richardson, Fount	USA
Robinson, J. A.	Summers
*Sisco, C. P.	Springdale
Sisco, Friedman	USA

WHITE COUNTY

Abington, E. H.	Beebe
Adair, T. L.	USA
Allbright, S. J.	Searcy
Dunklin, A. J.	Searcy
Emerson, A. G.	Bald Knob
Felts, W. R.	Judsonia
Hawkins, M. C., Jr.	Searcy
Huddins, A. H.	Searcy
Martin, J. A.	Bald Knob
McAdams, J. C.	Pangburn
Mobley, Hugh	USA
Peeler, C. M.	Pangburn
Rector, Jos. L.	USA
Rodgers, P. R.	Searcy
Ruff, John L.	USA
Sloan, D. W.	Beebe
Sloan, J. R.	Beebe
Sneed, J. W.	USA
Spain, A. L.	Letonia
Wilson, W. H.	Griffithsville

WOODRUFF COUNTY

Brewer, E. F.	Augusta
Dungan, C. E.	Augusta
Evans, R. H.	Chaffield
Hays, J. F.	Augusta
Maguire, F. C., Jr.	USA
Maguire, F. C., Sr.	Augusta
Morris, J. W.	McCrory
Wilkins, W. T.	USA
Williams, W. J. B.	Cotton Plant

PROCEEDINGS OF SOCIETIES

The Craighead-Poinsett County Medical Society was addressed at its dinner meeting in Jonesboro October 5th by John Carangelo, Little Rock, and H. H. McAdams, Jonesboro.

J. H. McCurry, Secretary.

WHAT OUR NAVY COLLEAGUES ARE READING

13 June 1944.

(MA)—R1—OIM

P3-3/P3—I (054-40)

To: All Ships and Stations.

Subject: Roentgenographic Examinations of the Chests of Navy and Marine Corps Personnel.

References: (a) Bumed form ltr. R-C A B, P3-3/P3-I (054), of 14 Apr. 1941, to Commandants Naval Districts, Commandants and Commanding Officers Shore Stations, Commanding General Marine Corps.

(b) Bumed form ltr. 23, R:JLA, P3/P3-I (054-40), of 5 Jan. 1942; Navy Department Bulletin, Cumulative Edition, 1943, p. 416.

(c) Bumed ltr. R-VC, P3-3/P3-I (054-40), of 8 Aug. 1942; Navy Department Bulletin, Cumulative Edition, 1943, p. 440.

(d) Bumed ltr. R-JLA, P3-3/P3-I (054-40), of 18 Feb. 1943, to all ships and stations.

(e) Bumed ltr. R1:JLA, P3-3/P3-I (054-40) of 23 Nov. 1943, to Commandants and Commanding Officers Naval Districts, Naval Training Schools, Naval Construction Training Schools, Marine Corps Recruit Depots. —Hospital Corps Quarterly, September, 1944.

"During every hour of stress or national emergency there is always a super-abundance of panaceas for all the fancied wrongs that may or may not beset the nation. The present time is no exception. Across the distant horizon we see a dark cloud gathering, we hear the distant rumble of social reformers, and the childish prattle of welfare workers that is utterly devoid of common sense, and we feel the hot breath of demagogues belching forth their theories of national, and more especially, medical economy. We look more closely and we recognize that cloud to be the Murray-Wagner Bill and we are relieved for we know that Socialized Medicine cannot be thrust on a democracy because its very conception is not only far-fetched, but foreign, its action is socialistic, its cost is prohibitive, and its end result is harmful. Surely this impractical and

vicious act does not deserve the courtesy nor dignity of further discussion."

From an address by L. H. McDaniel, Tyronza, to the graduating class, Saint Joseph's Hospital, Hot Springs National Park, September 27, 1944.

COMMUNIQUE

September 10, 1944.

To the Editor:

Thought it about time to drop you a line and let you know that you had the correct address. Have been receiving The Journal and Random Thots okay. We have enjoyed the jokes very much. None of the M. D.'s are from Arkansas. Have really moved around a lot and seen a great deal of the country—most of which I can't talk about. I really enjoy the news about fellow docs and what and where they are. Haven't run into any of my fellow statesmen, although I know that plenty are about.

My job of C. O. of this outfit keeps me on the move. In fact, I get pretty tired of pounding the leather of a jeep. It would be a pleasure to have a little of that Arkansas hot weather now. We are getting a lot of damp, rainy, cold weather, with a little sunshine thrown in, once in a while. Thank goodness, I have some nice sleeping equipment that I was lucky to get. Guess it will hold me to a few notes below zero. Have been living in some nice cow pastures recently and occasionally, a good muddy plowed field. Things are interesting enough now, but it would be nice to get under cover (in a building) once in a while. Keep up the good newsy section of Random Thots and also in The Journal.

Sincerely,

Wm. W. Johnston, Maj., M. C.

BURTRUM L. WARE, age 61, of Greenwood and Fort Smith, died suddenly October 12th. Born in Greenwood in 1883, he attended the schools of the county and graduated in medicine from the University of Arkansas School of Medicine in 1909. For a number of years he was associated with C. S. Means in practice at Jenny Lind but later moved to Greenwood, practicing there until ill health caused his retirement in 1942. He had served as president of the Sebastian County Medical Society and as its delegate to the Arkansas Medical Society, and was a member of the Masonic bodies and of the Methodist Church. Surviving relatives are his wife, two sons, one of whom, Capt. Prentis Ware, is in the Dental Corps overseas, and one daughter.

PERSONALS AND NEWS ITEMS

Maj. Samuel S. Kirkland, Van Buren, is now stationed overseas.

"Indications for Pelvioscopy in the Female" by Wm. B. Harrell, Little Rock (Major, M. C.), and Rafael Estevez, Aquadulce, Republic De Panama, appeared in The Southern Medical Journal for August.

T. L. Adair, Bald Knob, now stationed at Fort Francis E. Warren, Wyoming, has been promoted to captain.

Geo. C. Burton, Bald Knob, is taking a residency at the University of Iowa Hospitals, Iowa City, Iowa.

Lt. A. W. Strauss, Jr., Little Rock, is now stationed with the 1257th Engineer Combat Battalion, Camp Bowie, Texas.

Lt. Thos. S. Van Duyn, Stuttgart, is now stationed with a general hospital overseas.

W. A. Regnier, Crossett, now stationed overseas, has been promoted to major.

Dr. and Mrs. C. F. Cole, Prattsville, celebrated their fiftieth wedding anniversary October 8th.

Capt. C. C. Reed, Jr., Little Rock, is now assigned to Station Hospital, Camp Chaffee, Arkansas.

Maj. Alfred H. Hathcock, Fayetteville, is now stationed overseas.

Lt. Comdr. T. P. Foltz, Fort Smith, addressed the Little Rock Rotary Club September 28th on "Medical Service in World War II."

Fred Hames, Pine Bluff; D. A. Rhinehart, Little Rock; Maj. E. P. Griffin, Jr., Atkins, and W. R. Brooksher, Fort Smith, attended the meeting of the American Roentgen-Ray Society and of the Radiological Society of North America in Chicago during September.

T. T. Ross and L. L. Fatherree, Little Rock, attended the recent meeting of the American Public Health Association in New York.

Lt. Elbert H. Wilkes, Little Rock, is now stationed overseas.

O. R. Kelly, Sheridan, has been elected chairman of the Grant County Crippled Children's Association.

Paul Mahoney, Little Rock, recently attended clinics in Philadelphia and in the East.

Phillip T. Cullen, Little Rock, now stationed overseas, has been promoted to captain.

Lt. Loyd F. Ritchey, Little Rock, is now stationed overseas.

Pearl Waddell, Fort Smith, spent a recent vacation in Georgia.

H. K. Wright, Hot Springs National Park, has been discharged from military service and has returned home.

F. A. Corn, Lonoke, has been discharged from military service and has returned home.

Capt. Henry H. Atkinson, Crossett, is now stationed overseas with a general hospital.

Doris A. Baldridge, Conway, is now on duty with the Monroe County (Florida) Health Department, Key West.

O. L. Atkinson has been elected a director of the Hampton Chamber of Commerce.

Capt. James D. Hays is now stationed at Camp Elis, Illinois.

Ralph M. Sloan recently addressed the Jonesboro Life Underwriters Club on the Murray-Wagner bill.

Dr. and Mrs. C. W. Hall, Greenwood, attended the World Series in St. Louis.

Capt. W. O. Loftis, Pocahontas, is now assigned to Medical Service School, Fort Sam Houston, Texas.

E. C. Moulton, Fort Smith, and Virgil Payne, Pine Bluff, attended the meetings of the American Academy of Ophthalmology and Otolaryngology in Chicago during October.

Robert H. Johnston, Clarksville, now stationed overseas, has been promoted to lieutenant-colonel.

COUNTY SOCIETIES

1944

ARKANSAS MEDICAL SOCIETY

COUNTY	PRESIDENT	ADDRESS	SECRETARY	ADDRESS
ARKANSAS	M. C. John	Stuttgart	S. A. Drennen	Stuttgart
ASHLEY	M. C. Crandal	Wilmot	L. C. Barnes	Hamburg
BENTON	A. J. Harrison	Springdale	Geo. M. Love	Rogers
BOONE	M. E. Rust	Harrison	Ross Fowler	Harrison
BRADLEY	W. N. Roark	Hermitage	W. J. Hunt	Warren
CARROLL	A. L. Carter	Berryville	D. K. McCurry	Green Forest
CHICOT	B. C. Clark	Lake Village	M. K. Bottorff	Lake Village
CLARK	Chas. K. Townsend	Arkadelphia	Joe W. Reid	Arkadelphia
CLAY	N. J. Latimer	Corning	J. E. McGuire	Piggott
COLUMBIA	W. H. Horn	Magnolia	T. H. Jones	Waldo
CONWAY	J. H. Halbrook	Plumerville	T. W. Hardison	Morrilton
CRAIGHEAD-POINSETT	Ira W. Ellis	Monette	J. H. McCurry	Cash
CRAWFORD	F. A. Boomer	Van Buren	S. C. Grant	Mulberry
CRITTENDEN	T. S. Hare	Crawfordsville	L. C. McVay	Marion
CROSS	A. F. Barr	Cherry Valley	Thos. Wilson	Wynne
DALLAS	H. A. Cheatham	Princeton	J. E. M. Taylor	Sparkman
DESHA	H. A. Rands	Dumas	Gibbs Biscoe	Dumas
DREW	J. P. Price	Monticello	L. F. Billingsley	Monticello
FAULKNER	E. M. Ingram	Enola	I. N. McCollum	Conway
FRANKLIN	W. C. Porter	Ozark	W. H. Gibbons	Ozark
GARLAND	F. S. Tarleton	Hot Springs	W. E. Gray	Hot Springs
GRANT	O. R. Kelly	Sheridan	John W. Cole	Sheridan
GREENE	J. A. Dillman	Paragould	W. McD. Lamb	Paragould
HEMPSTEAD	Don Smith	Hope	H. G. Heller	Hope
HOT SPRING	R. V. McCray	Malvern	M. D. Prickett	Malvern
HOWARD-PIKE	T. F. Alford	Murfreesboro	M. D. Duncan	Murfreesboro
INDEPENDENCE	W. P. Gray	Batesville	F. Q. Wyatt	Batesville
JACKSON	E. L. Watson *	Newport	J. B. Ivy	Tuckerman
JEFFERSON	T. J. Cunningham, Jr.	Pine Bluff	Chas. W. Reid	Pine Bluff
JOHNSON	Earle H. Hunt	Clarksville	G. R. Siegel	Clarksville
LAFAYETTE	F. E. Baker	Stamps	A. W. Keith	Stamps
LAWRENCE	J. L. Merrell *	Hoxie	Chas. D. Tibbels	Black Rock
LEE	C. W. Chaffin	Moro	N. C. Hodge	Marianna
LINCOLN	B. L. Bailey	Sterlington, La.	C. W. Dixon	Gould
LITTLE RIVER	E. W. Yates	Foreman	C. A. Harding	Ashdown
LONOKE	S. S. Beaty	England	O. D. Ward	England
MILLER	Harry E. Murry	Texarkana	G. W. Parson	Texarkana
MISSISSIPPI	T. F. Hudson	Luxora	P. W. Turrentine	Osceola
MONROE	M. L. Dalton	Brinkley	W. L. Boswell	Clarendon
MONTGOMERY	J. H. McLean	Caddo Gap	G. E. Watkins	Mt. Ida
NEVADA	T. W. McDaniel	Boughton	J. W. Kennedy	Prescott
OUACHITA	J. L. Rushing	Chidester	R. B. Robins	Camden
PHILLIPS	W. C. King	Helena	M. Fink	Helena
POLK	F. A. Lee	Vandervoort	E. M. Miers	Mena
POPE-YELL	A. B. Tate, Jr.	Russellville	W. O. Young	Russellville
PRAIRIE	J. R. Lynn	Hazen	J. C. Gilliam	Des Arc
PULASKI	Carl A. Rosenbaum	Little Rock	E. D. Fletcher	Little Rock
RANDOLPH	J. E. Smith	Reyno	M. A. Baltz	Pocahontas
SALINE	Dewell Gann, Sr.	Benton	C. W. Jones	Benton
SEARCY	E. G. Fendley	Leslie	J. O. Leslie	Marshall
SEBASTIAN	C. W. Hall	Greenwood	D. W. Goldstein	Fort Smith
SEVIER	R. C. Dickinson	Horatio	C. E. Kitchens	DeQueen
ST. FRANCIS	D. A. Mohler	Brinkley	J. O. Rush	Forrest City
UNION	Berry L. Moore	El Dorado	M. V. Russell	El Dorado
WASHINGTON	J. P. Delaney	Fayetteville	Ruth E. Lesh	Fayetteville
WHITE	Sam J. Allbright	Searcy	D. W. Sloan	Beebe
WOODRUFF	J. W. Morris	McCrory	C. E. Dungan	Augusta

* Deceased

Art. B. Martin, Fort Smith, now stationed at Camp McCoy, Wisconsin, has been promoted to captain.

Capt. Hunter C. Sims, Blytheville, is now on duty overseas.

Capt. W. B. Connolly, Helena, is now stationed with the 139th Evacuation Hospital, Camp Shelby, Mississippi.

Lt. Huie H. Smith, Little Rock, is now assigned to Station Hospital, Buckley Field, Colorado.

Col. Howell Brewer, Hot Springs National Park, is now commanding officer, Station Hospital, Fort Story, Virginia.

The Fifth Councilor District Medical Society met in Camden October 12th for the following program: "The Medical Profession and the Governor," Governor-Elect Ben Laney, Camden; "The Hollingsworth Act," C. A. Archer, De-Queen, and "A Program for the Arkansas Medical Society," W. R. Brooksher, Fort Smith.

The Benton County Medical Society met in dinner session at Rogers October 12th for the following program: "Trichomonas Vaginalis," Clyde L. McNeil, Rogers.

Geo. M. Love, Secretary.

The Sebastian County Medical Society was addressed October 10th by Drs. Graham and Greenblatt, U. S. Public Health Service, Hot Springs National Park, on "The Use of Penicillin in the Treatment of Syphilis and Gonorrhea."

D. W. Goldstein, Secretary.

ATTENTION, DOCTORS' WIVES

The Auxiliary to the Arkansas Medical Society has a big task again in putting on the Essay Contest. The subject this year will be: "Senate Bill 1161—a Menace to Medical Welfare."

It behooves the medical profession as well as all trade and other professional groups to get before the public the dangers to free enterprise and medical health if the Wagner-Murray bill passes Congress. No better way to do this than by putting on an Essay Contest in every high school and college in the state.

The Arkansas Medical Society appropriated \$300 as prizes for the contest and is counting on the wives of doctors in the state to promote the work. Since there are only about 28 counties

which have medical auxiliaries, I am appealing to you doctors' wives in those counties which are not organized to contact the high schools and colleges in your various towns. Please take the Essay Contest Instructions printed in this issue to your local schools, solicit their participation, and write me for portfolios of reference material for the school libraries, and other helps in promoting the work.

Those counties which are organized have received instructions for conducting the contest and I am sure are already at work.

Every doctor and wife can help promote the contest by TALKING Essay Contest to every senior high school and college student with whom you come in contact. I shall certainly appreciate ANYTHING you may do to help.

Mrs. W. J. Hunt,

Chairman, Essay Contest.

COMMUNIQUE

September 25, 1944.

To the Editor:

This is not a "here I am doing wonders, etc." letter, but just a word to you to send greetings and to tell you how much I sincerely enjoy all of the news that you so faithfully arrange for us to have.

After 18 months "out there," I had an extensive one week home and have been here at the Naval Hospital in San Diego since. I am having excellent duty and doing orthopedic surgery solely. This place is tremendous with 10,000 patients, 1,400 of which are orthopedic and naturally I am getting some very valuable experience. The only other Arkansas man on the staff is Gaston Hebert from Hot Springs.

I hear directly or indirectly of the doings of the boys around the country there. Our boy Bob seems to be really in politics, having warmed up on medical organizations in recent years. Too bad about T. Foltz not being able to get his house back.

I am beginning to realize how hard all you fellows have been and are working but I couldn't appreciate the fact until I got back to the States. As a matter of fact, this is the only service organization I have seen yet that is understaffed and we are operating with about 65 per cent of our quota of doctors.

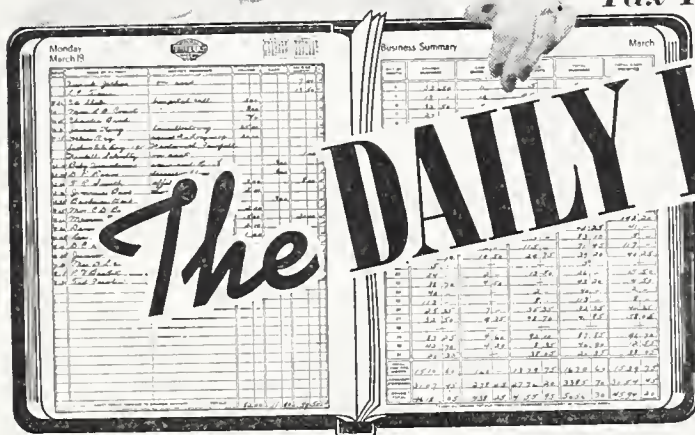
Do not want to make you feel bad but our highest temperature has been 84 and it averages about 76 out here, which is one of the few attractive things I've found about Southern California under war conditions.

Sincerely, Joe B. Wharton.



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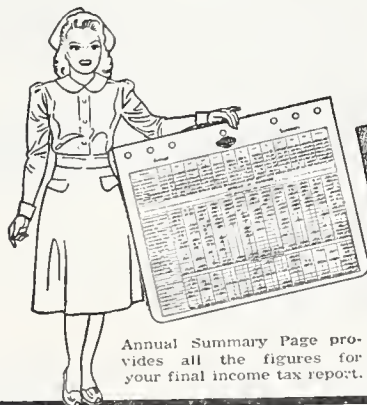
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RANDOM THOTS OF THE SECRETARY

September 22nd. Today we debunk the vitamins in a talk to the civic club and find our appraisal of the gigantic promotion involving these substances quite well received.

September 24. Arriving Chicago tonight we encounter a new home front horror and stand in line for 80 minutes in order to register at the hotel. We hope some kindly disposed service colleague will send us some K-rations to carry along on our next trip here in November.

September 25th. Starting a week with the radiologists, seeing for the first time in many, many years, Hobbs, who has the similar distinction of being a Tulanian of the 1919 group; also seeing Rhinehart, Fred Hames, C. H. Frank and George Burton who has cast the dust of general practice from his feet at Bald Knob to become a radiologist, and may he not regret it.

September 26th. The talk today is of carcinoma of the testicle with much offered on a relatively sterile subject.

September 27th. Procurement and Assignment catches up with us today and we begin to think that we are still at home. Lunching with the Southern radiologists today, the party being crashed by many a Yankee who claims the right to attend by marriage or some such pretext. Meeting Robinson from the big town of New York but who still thinks of Western Grove and would like to come back to shoot quail. Also meeting Major Griffin, who claims Atkins as the home town, but who is an old settler at La Garde General Hospital, New Orleans, and may never get away. Visiting, too, Olin West, always a pleasure, and driven to town by the AMA secretary, who is a better driver than Goldstein, but not much more so.

September 28th. Tonight dining with the Hames at a restaurant discovery of theirs where we find the pike something to write home about and more to be appreciated than those Fred did not catch in Wisconsin last week.

September 29th. Chicago and Southern takes us above the clouds, Chicago to Memphis, and a more beautiful sight we've never seen, soft white clouds billowing away over acres of space, interspersed now and then with dark craters resembling canyons of the west, but mostly giving the appearance of a tremendous meringue pie for giants of old. Delayed over Memphis by traffic congestion and on into Little Rock below the clouds to see Forrest City, Brinkley, Lonoke and others through which we have driven at lessened speed along U. S. 70 and thence by rail and home ahead of schedule plans made a week ago.

October 9th. Wishing Sarah and Stanley Gates every bit of happiness so well deserved.

October 11th. Take three men: the musicians' James Petrillo, Montgomery Wards' Sewell Avery and the president of the United States. Who's boss?

October 12th. With the family to Camden in 93 minutes by air, finding that city considerably nonplussed by the location of a war industry with considerable more confusion than the good people expect sure to follow. The Fifth District meets, the last session for the duration in Camden we are told by the hotel folks, hearing Ben Laney talk straight on his plans for Arkansas and, in particular, for the participation of state government in medical affairs, an expression with which we cannot differ. In the evening with the Robins' as house guests, it being our lot to have more sleep than Bob because we do not practice obstetrics in Camden.

October 13th. Homeward with haze over Ouachita County but lifting as we reach Clark County and a ride to write home about on into Fort Smith, noting in profu-

sion over Southern Sebastian and all of Scott County, the Federal government's latest benefaction to the farmer—ponds, constructed on each farm from a Federal outlay of three hundred dollars per pond.

COMMUNIQUE

September 12, 1944.

To the Editor:

I enjoy the News Letters with comments and gags about our Arkansas doctor friends. Received two while on ** and learned that Jack Agar was with the ** division, so looked him up and we had quite a nice session talking about you guys back home. We had planned a repeat performance but I had to shove off for ** and didn't get to see him again.

Certainly appreciate your efforts in carrying on back home, especially the fight to preserve our way of practicing medicine.

Sincerely,

John W. Harper,
Lt., M. C., USNR.

WOMEN'S AUXILIARY NEWS ESSAY CONTEST

Sponsored by the Women's Auxiliary to the Arkansas Medical Society

Subject: "Senate Bill 1161—a Menace to Medical Welfare."

Contest open to all college and tenth, eleventh and twelfth grade high school students in Arkansas.

The essay should be limited to not more than 2,000 words and should be typewritten if possible, although manuscript legibly written in ink will be accepted.

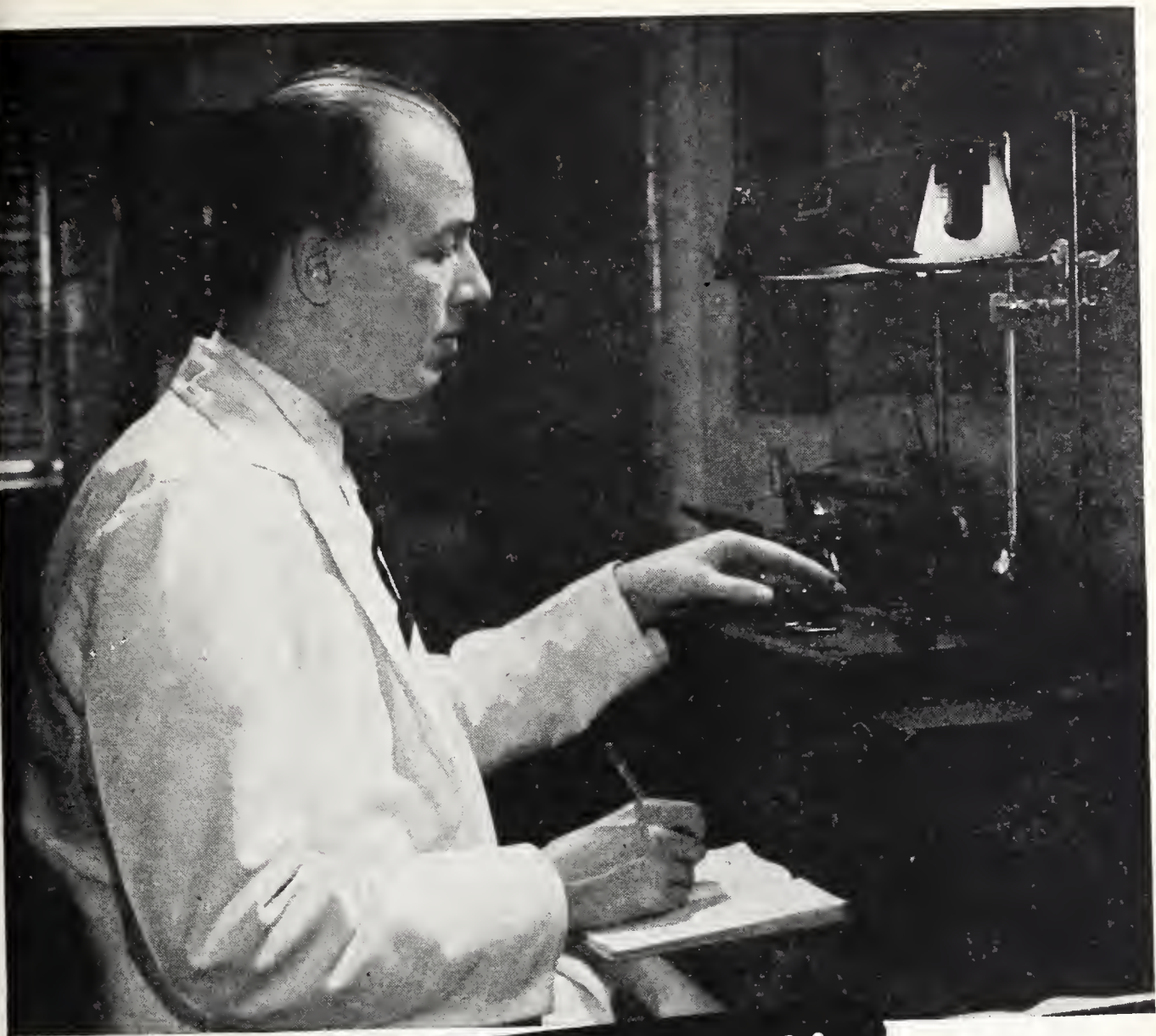
A portfolio of material dealing with the subject will be furnished each high school and college.

Essays will be judged on the basis of accuracy of facts, intelligent grasp of the subject, and originality. All essays must be in the hands of the county chairman of the Essay Contest not later than March 1, 1945, and must be sent to the state chairman, Mrs. W. J. Hunt, Warren, Arkansas, not later than March 15, 1945.

Prizes, both in the high school and college groups, will be awarded as follows:

First prize.....	\$100 War Bond
Second prize	50 War Bond
Third prize	25 War Bond
To the teacher who sponsors the winning essay	25 War Bond

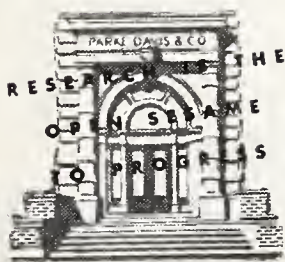
The student's name and grade, the location of



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the school, and the name of the teacher who sponsored the essay shall be placed in a sealed envelope and clipped to the essay. The student's name **must not** appear on the essay.

The decision of the judges shall be final, and all papers submitted become the property of the medical auxiliary.

October 10, 1944

Mrs. B. L. Ware, new president of the Auxiliary of the Sebastian County Medical Society, assumed her duties at a luncheon and business meeting of the Auxiliary October 10th. Mrs. Walter G. Eberle and Mrs. S. P. Stubbs were hostesses.

New officers serving with Mrs. Ware are Mrs. W. F. Rose, past president, who automatically becomes vice-president; Mrs. S. P. Stubbs, succeeding Mrs. D. W. Goldstein as secretary; Mrs. Walter G. Eberle, treasurer, succeeding Mrs. S. P. Stubbs.

Standing committees appointed by the president for the year are as follows: Public Relations, Mrs. M. E. Foster, chairman, Mrs. A. A. Blair, Mrs. T. P. Foltz, Mrs. Kenneth Thompson, Mrs. Fred Krock; Hygeia, Mrs. J. L. Kellum, chairman, Mrs. I. F. Jones, Mrs. B. B. Bruce, Alma; Mrs. Minnie U. Rutherford Fuller, Magazine; Mrs. S. P. McConnell, Booneville; Telephone, Mrs. Ralph Crigler, chairman, Mrs. W. F. Adams, Mrs. D. W. Goldstein; Program, Mrs. J. S. Southard, chairman, Mrs. Walter G. Eberle, Mrs. C. S. Means; Health, Mrs. Everett Moulton, chairman, Mrs. Mabel Wood Scott, Mrs. C. S. Holt, Mrs. A. F. Hoge; Courtesy, Mrs. Charles Chamberlain, chairman, Mrs. J. E. Stevenson; Legislation, Mrs. W. R. Brooksher, chairman, Mrs. H. H. Smith, Mrs. H. A. Dorsey, Mrs. G. G. Wood, Huntington; Cancer Control, Mrs. S. J. Wolferman, chairman, Mrs. W. R. Brooksher, Mrs. C. W.

Hall, Greenwood; Mrs. Merle Wood, Huntington; Publicity, Mrs. W. F. Rose.

New business taken up by the new president included a contribution of \$10 to the Arkansas Medical Student Loan Fund. The Auxiliary voted to contribute to the Earle Chambers Library Fund, a sum for the purchase of books for the State Tuberculosis Sanatorium at Booneville.

The members each will contribute a Christmas box for the station hospital at Camp Chaffee, through the Sebastian County Chapter of the American Red Cross.

Members attending the luncheon were Mrs. B. L. Ware, Mrs. D. W. Goldstein, Mrs. M. E. Foster, Mrs. Mabel Wood Scott, Mrs. W. F. Rose, Mrs. C. W. Hall of Greenwood; Mrs. W. R. Brooksher, and the hostesses, Mrs. Eberle and Mrs. Stubbs.

Mrs. W. F. Rose, Publicity Chairman
of The Sebastian County Medical Society
Auxiliary

BOOK REVIEWS

Dr. Colwell's Daily Log for Physicians. Champaign, Illinois: Colwell Publishing Company. Price \$6.

The Journal has continued to give this one-volume system of record-keeping its approval. The fact that every physician who once uses it, returns to it year after year, is perhaps its best recommendation. We consider it an indispensable item of equipment for the business side of medical practice and urge physicians unacquainted with it to give it a trial in 1945.

Metastases, Medical and Surgical: By Malford W. Thewlis, M. D., Attending Specialist in General Medicine, United States Public Health Service Hospitals, New York, New York, etc. 230 pp. 13 illustrations. Price \$5.00. Charlotte, North Carolina: Charlotte Medical Press, 1944.

The author has written a book designed to be of help to all physicians, discussing general phases of the subject and then regional areas, infections, neoplasms, infectious diseases. The importance of the surgeon's knowledge of cancer and its metastatic spread is emphasized.

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The JOURNAL

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Vol. XLI

LITTLE ROCK, ARKANSAS, DECEMBER, 1944

No. 7

MODERN CONCEPTS OF CARDIO-VASCULAR DISEASE

COMMITTEE ON THE HEART ARKANSAS MEDICAL SOCIETY

C. T. CHAMBERLAIN, M. D., Chairman
Fort Smith

At this time of the year upper respiratory tract infections will begin to make their appearance, reaching their highest incidence in this climate during the months of January and February. The Heart Committee feels, therefore, that the following number of "Concepts" (No. 10, Volume XII, by Kuttner) can be read with interest as well as instruction by the profession. Any rational measures that can be carried out to prevent acute recurrences of rheumatic fever in children as a result of streptococcal respiratory infections certainly deserve consideration and trial.

"Rheumatic fever is a chronic generalized disease affecting many tissues and organs and often damaging the heart permanently. Its course in different individuals varies greatly; in some chronic valvular disease develops insidiously; in others, the so-called continuous or polycyclic type, clinical or laboratory signs indicating that the rheumatic process is not quiescent, persist for months and years. In the majority of cases, however, serious cardiac damage is the result of repeated severe rheumatic attacks. Between the acute bouts these patients show no demonstrable evidence of rheumatic activity. It is in this latter type, usually described as monocyclic, that prophylactic measures are most likely to prove effective.

At the present time no specific therapy is available. Sulfonamide drugs not only fail to benefit patients with active rheumatic fever, but actually tend to increase the severity of the rheumatic symptoms, and are contraindicated even in rheumatic subjects with signs of low grade rheumatic activity. On the other hand, it was first shown by Thomas et al., and by Coburn and Moore that the administration of daily prophylactic doses of sulfanilamide to rheumatic individuals in whom the rheumatic process was in-

active, prevented streptococcal pharyngitis and that patients so protected, escaped rheumatic relapses. It was found essential to prevent infection with Group A hemolytic streptococci. Sulfanilamide given once the upper respiratory infection had developed, proved ineffective in preventing rheumatic recurrences.

These findings have been confirmed by other investigators. None of these observers, however, had the opportunity of studying a control group living under identical conditions, where exposure to Group A hemolytic streptococci could be determined. It was thought, therefore, that the value of sulfanilamide prophylaxis could be more accurately assessed in an institution where the children were under daily medical supervision and careful bacteriological studies could be made.

Type of Institution. Irvington House is a sanatorium for rheumatic children ranging in age from 7 to 15 years. Each year 108 children, 66 girls and 42 boys, were selected during the summer and fall months. With few exceptions no new children were admitted from December 1 until the end of May. Rectal temperatures and pulse rates were taken three times daily. Throat cultures to determine the presence of Group A hemolytic streptococci were obtained routinely once a week on every child throughout the year. Additional throat cultures were taken on two successive days on children who developed symptoms of any kind. Antistreptolysin O titers were determined routinely every 3 to 6 weeks or more often following upper respiratory infections or during rheumatic activity.

Prophylactic Sulfanilamide. During two successive winters, 1940-41 and 1941-42, the patients were divided into two groups matched as closely as possible in regard to age, sex, number of previous rheumatic attacks and cardiac findings. Beginning in October, 1940, and continuing until the following June, 54 children were given small daily doses of sulfanilamide and 54 served as controls. The same procedure was followed during the second winter, 23 children who were in the institution during 1940-41 and who

remained the following year, and 31 new patients received sulfanilamide. The control group comprised 50 children. Only children who showed no clinical or laboratory evidence of rheumatic activity were given the drug. Weekly leucocyte counts and bimonthly hemoglobin determinations were done on all children receiving sulfanilamide. Samples of blood for the determination of sulfanilamide levels were taken every three weeks before 8 a. m. dose of sulfanilamide.

1940-1941

Control Group. From October, 1940, until February, 1941, 30 of the 54 children in the control group developed streptococcal upper respiratory infections due to a single type of Group A streptococcus, type 15. After a latent period varying from 3 to 21 days, 14 of these 30 patients developed definite rheumatic manifestations and 4 additional children laboratory evidence of rheumatic activity. Two children in the control group became "contact" carriers of type 15 streptococcus without developing symptoms of any kind.

Sulfanilamide Group. Only one child receiving sulfanilamide as a prophylactic contracted pharyngitis due to type 15 streptococcus. No rheumatic sequelae developed. Ten children in this group became "contact" carriers of the epidemic inducing strain.

1941-1942

The results were similar to those obtained the previous winter.

Control Group. An outbreak of upper respiratory infections due to a single type of Group A streptococci, provisional type 36, occurred. From October, 1941, until February, 1942, 18 of 50 children, who were not receiving sulfanilamide, contracted pharyngitis due to this type. Following a latent period varying from 10 to 18 days, 10 of these 18 children developed rheumatic sequelae.

Sulfanilamide Group. Again only one child receiving sulfanilamide contracted pharyngitis due to the epidemic strain of streptococcus. Following a latent period this boy developed mild rheumatic manifestations lasting 10 days.

Four children in this group became "contact" carriers of provisional type 36 streptococcus.

Summary: During both years the contrast in the incidence of streptococcal upper respiratory infections and rheumatic relapses in the treated and untreated groups was striking. Only 2 of 108 children receiving sulfanilamide contracted streptococcal pharyngitis and only one of these developed rheumatic manifestations. Among the

104 children serving as controls 48 contracted streptococcal pharyngitis and 23 of these 48 or nearly half, developed definite rheumatic relapses and 5 additional children had laboratory evidence or mild clinical symptoms suggesting rheumatic activity. No rheumatic recurrences were observed in children who escaped streptococcal upper respiratory infections.

Dosage. During 1940-41 an average blood level of 2 mgm. % was maintained. In most instances children weighing 75 lbs. or less were given 1 gram of sulfanilamide daily in 3 divided doses and children weighing more than 75 lbs. 1.3 to 2 grams. During 1941-42 the dosage was decreased slightly so as to maintain an average blood level of 1.5 mgm. %.

During each year one child developed streptococcal pharyngitis in spite of sulfanilamide prophylaxis. In one instance infection occurred in a patient with a blood level of 2 mgm. %. This girl may have been particularly susceptible to the epidemic inducing strain of streptococcus or the infecting dose may have been unusually large. In the case of the other child the blood level at the time of the infection was 0.95 mgm. %. In our opinion a concentration of 1 mgm. % is probably too low to be effective.

Toxic Reactions. The incidence of toxic manifestations in our series was high, 15%, but no serious reactions were encountered. The following symptoms were observed: fever, abdominal pain, nausea, erythema and urticaria. A gradually developing leucopenia accompanied by a fall in polymorphonuclear leucocytes was encountered in 3 children. The blood picture returned to normal within a few days when the drug was discontinued.

The possibility that agranulocytosis may develop in patients receiving prophylactic sulfanilamide must always be borne in mind and constitutes the greatest hazard of this form of treatment.

General Condition of Children Receiving Prophylactic Sulfanilamide. The children who did not develop toxic reactions within 5 weeks tolerated the drug well. There were no subjective complaints. In most instances the patients continued to gain weight at the same rate as before medication was started. The hemoglobin of most children receiving sulfanilamide tended to fall slightly and remained at a level somewhat lower than normal throughout the course of the treatment. The hemoglobin rose to its previous level when the drug was discontinued.

Administration of Sulfanilamide During Two

Successive Winters. Twenty-three patients who received sulfanilamide during both winters showed no evidence of sensitization when the drug was restarted after a lapse of 5 months.

Conclusions. In considering any prophylactic measure the danger inherent in the treatment must be weighed against the seriousness of the disease. Many observers are of the opinion that the severity of rheumatic fever in this country is declining. In any given child, however mild the first rheumatic manifestations may be, it is impossible to predict the subsequent course of the disease. The ultimate value of sulfanilamide by prophylaxis can be determined by protecting rheumatic individuals from streptococcal upper respiratory infections not for 1 or 2 years but for at least 5 years. To date no reports on the prophylactic value of some of the less toxic sulfonamide drugs such as sulfadiazine have been published. It seems probable, however, that less toxic compounds as effective as sulfanilamide in preventing rheumatic relapses will be developed. In the meantime the sulfanilamide studies have added further evidence that infection with Group A hemolytic streptococci plays an important role in the etiology of rheumatic fever."

Acknowledgment is hereby made of permission by the American Heart Association to publish the above.

COMMUNIQUE

November 3, 1944.

To the Editor:

More ** casualties continue to keep our large evacuation hospital a very busy one. We are seeing these cases quite early and are able to return a high percentage of them to duty. The ** Field Hospital is celebrating its 18 months overseas with a barbecue, competitive sports and a movie. Wish you were to be one of our honored guests. We are rather proud of our softball team as it is leading the league. Another six months and we are due for rotation. We all have great hopes but are prepared for disappointment. So far the rotation plan in this theater has not worked very well. I'd like to take you on ward rounds in our hospital as we have many very interesting cases. Just at present we are encountering scrub typhus and tsutsugamushi disease.

Sincerely,

R. H. Johnston,
Lt. Col., M.C.

CARCINOMA OF THE LARGE BOWEL

WILLIAM G. COOPER, II, M. D.

University of Arkansas School of Medicine, Little Rock

Carcinoma of the large bowel is a fairly common variety of carcinoma in any tumor clinic. In recent years great advances have been made in the technical aspect of the treatment of this lesion, but corresponding steps toward improvement in early diagnosis are still lacking. It is proposed to give a general summary of the present status of large bowel carcinoma, drawing freely from the recent literature.

As is true of cancer anywhere, no etiological agent for carcinoma of the large bowel is known. It has been suggested that all polyps of the colon will eventually give rise to malignancy, and some authors feel that all large bowel cancers begin thus. This is not susceptible of proof and even if it were accepted as fact, would only push the question back one more step as we do not know the cause of the polyp. There is, however, one well recognized condition, multiple familial polyposis, where the association of carcinomatus change with the pre-existing lesion is very definite. It has long been known that there is a tendency, apparently inherited, which runs in certain families for a large proportion of the individuals to develop multiple polypi in the large bowel. These same polypi go on to malignant change in almost 100 per cent of the cases if the individual lives long enough. In this situation prophylactic surgery can and should be done early before malignant degeneration has occurred.

Pathologically the lesions of the large bowel are for the most part adenocarcinomas. Other microscopic types of lesions, such as sarcoma and lymphosarcoma, etc., do occur but are rare. Peri-anal squamous cell carcinomas form the exception to this statement. Although they arise from cutaneous structures, they must be considered here as we believe they require the same treatment as rectal lesions proper, viz.: rectal resection. Carcinomas of the bowel have been graded by Dukes in England on the amount of gross involvement of surrounding tissues, and by Brodus in this country on the microscopic appearance of the individual lesion. Both these writers feel that they can form an idea as to the prognosis of the individual case by their findings, and surgeons certainly agree that the extent of the involvement of the draining lymph nodes, and of the liver is important as is the degree of anaplasia found. A lesion confined within the bowel

wall without spread has a good prognosis, conversely widespread lymphatic, hepatic, and blood vessel involvement are of poor prognostic import. It should be noted that the size of the primary growth itself is not necessarily a gage of prognosis, for many large fungating tumors exist for a long period of time without the occurrence of metastasis.

It is in the realm of early diagnosis that further improvement in end results is to be sought. Typically, carcinoma of the cecum produces anemia, weight loss, cachexia, bloody stool, and occasionally an abdominal mass. Lesions in the transverse and descending colon tend to cause obstruction. Those located in the rectum which form a large per cent of all large bowel tumors, produce tenesmus, hemorrhoids, and again melena. The clinical symptoms have a common basis, change in the physiology of bowel habits. When this finding is elicited in the middle-aged patient coupled with the presence of blood in the stool, the diagnosis of carcinoma of the large bowel is made. If this knowledge can be applied earlier in the course of the disease, a larger number of patients could then be referred for surgical treatment at a time when curative therapy is possible. At present it is not being done for three reasons. First, in some instances the patient through lack of education is unaware of the significance of his symptoms and does not seek medical advice. Secondly, at times the failure is on the part of the busy general practitioner who first sees the patient and does not investigate his complaints with proper indulgence. Thirdly, we must acknowledge that in the occasional rare case, carcinoma of the bowel exists for a long period without giving rise to any symptoms of importance.

Lay education must be continued until patients are taught to go to their family physician because they have suggestive symptoms instead of waiting till frank distress forces them to seek aid. Once the patients present themselves to the family physician, it is the doctor's duty to use all the now well recognized diagnostic procedures. This must, of course, include: a case history, rectal examination, determination of the presence or absence of melena, a sigmoidoscopic examination under adequate conditions, and expert examination of the bowel by means of a barium enema and fluoroscopy. It is said that 20% of the patients presenting themselves for treatment of carcinoma of the large bowel have had previous hemorrhoidectomies. In these cases one can not escape the conclusion that earlier diagnosis was possible and was missed by failure

of the first physician consulted to properly evaluate the patient's symptoms.

Our present treatment of these cases is the result of work done by many persons. It has been demonstrated that the carcinoma grows slowly at the site of origin and takes from six to twelve months to completely encircle the bowel. It then spreads through the bowel wall to the adjacent lymph nodes and also either by lymphatics or by the blood stream to the liver and elsewhere. The rare squamous cell carcinoma arising around the anus may metastasize early to the inguinal lymphatics. As these cases may be still curable when lymphatic metastasis has taken place, it is obvious that treatment must include removal of the potentially contaminated lymph nodes. X-ray is without avail as far as cure is concerned although its aid in diagnosis is unquestioned.

Most patients suffering from carcinoma of the bowel should be subjected to radical removal of the lesion. The surgical treatment must include not only excision of the bowel itself, which is easy, but of all the draining lymph nodes available. On this point there is no disagreement, and in view of the lethal nature of the lesion one's attitude should be extremely radical in any given case. The validity of contraindications to operation must be always questioned, for resection should often be undertaken in spite of the finding of a huge mass, enlarged lymph nodes, or even liver metastasis. A large local lesion may be a comparatively benign growth with an excellent prognosis. Enlarged nodes are frequently inflammatory rather than malignant and the differentiation can not be made by gross examination. Patients have been known to live over five years in comfort following radical removal of a large bowel carcinoma, even in the presence of hepatic metastasis, whereas refusal of operation leads inevitably to an early and disagreeable death.

The technique of accomplishing this surgical procedure is of importance. However, it is our personal feeling that each individual surgeon produces the best results when he uses the standard method with which he is most adept. Details of adequate pre-operative care, continuous spinal anesthesia, the use of steel wire for the abdominal closure, and multiple blood transfusions as indicated have been sufficiently emphasized in special articles. If one performs a radical operation upon two-thirds of the patients he sees with a mortality of 10% he can feel that he is accomplishing his duty.

The surgeon should never hesitate to establish

a permanent colostomy if necessary. As Lahey has emphasized, the use of a colostomy is in bad odor because it was previously done as a palliative measure and the obstructing distal growth was not removed. This type of colostomy is an abomination. On the other hand, a colostomy established when the offending lesion below is removed need not interrupt the ordinary social life of its possessor. It has been found that if the patient will irrigate his colostomy thoroughly at night, then, during the day, wear a soft cloth over the opening, supporting it with a girdle of the ordinary two-way stretch variety, he will soon be able to resume normal activities without worry. Some patients insist upon using a so-called colostomy belt. This contraption invariably produces a hernia around the colostomy stroma and leads to distressing symptoms. The involuntary bowel movements which necessarily follow will then add their bouquet to that of the warm rubber of the bag, producing an offense. This situation is unnecessary as has been proven by many of our own patients.

To summarize, treatment of carcinoma of the large bowel is at present rather standardized. None will dispute the statement that radical surgical removal of the lesion is the only indicated therapy. The better clinics have a resectability rate of around 65% with a mortality of 10%, and this yardstick is slowly being improved. The hope for better curability rates now seems to lie in earlier diagnosis which will come only through the increased realization of the importance of change of bowel habits in the middle-aged patient.

COMMUNIQUE

October 6, 1944.

To the Editor:

I recently received my membership card for 1944 which was much appreciated. Also have been receiving the Journal more or less regularly. I enjoyed the recent letter from you; also one from Dr. H. Fay H. Jones.

No one is more or could be more anxious to get back in Arkansas and meet with the Society than I. As you know, I have never had the privilege to meet as a member. However, I am making it okay and hope I will be able to stay until it is over over here, then I shall hope to return to Arkansas to stay. Kindest regards to all the "medics" at home.

James H. Moseley,
Captain, M.C.

ARKANSAS STATE BLOOD PLASMA PROGRAM

PAUL CHADBOURNE ESCHWEILER, M.D., F.A.C.P.
Little Rock

In the spring of 1941, a grant by the Gus Blass Company of Little Rock made possible purchase of equipment to establish a Blood Bank and a plasma processing plant at the University of Arkansas School of Medicine. The plant was completed and the first batch of desicated blood plasma was processed in January, 1942.

During 1942 and 1943 the Medical School Blood Bank served the patients in the University Hospital and, when called upon, the private hospitals in Little Rock. Powdered plasma was supplied to a few physicians throughout the state and to the Pine Bluff Arsenal. Volunteer donors were taken through the Central Volunteer Bureau of Little Rock.

Extension of a program on a state-wide basis was made possible in December, 1943, by a grant from the Free and Accepted Masons, Grand Lodge of Arkansas, and additional funds from the Gus Blass Company.

The organization of the State Blood Plasma Program began with the formation of a State Advisory Board, comprising the following individuals: Dr. Byron L. Robinson, dean of the Medical School; Dr. Paul C. Eschweiler, professor of medicine and director of the Blood Bank and the State Plasma Program; Dr. S. J. Albright, president of the Arkansas Medical Society; Dr. T. T. Ross, director of the State Health Department; Noland Blass, president of the Gus Blass Company of Little Rock; W. A. Thomas, grand secretary of the Grand Lodge, Free and Accepted Masons; and Joshua K. Shepherd, inspector general of Scottish Rite Masonry (Active). This group held several meetings and formulated the general policies and plans for the program. Mrs. Adrian Brewer was then appointed as executive secretary on a full time salary basis.

The following individuals in each county were sent a copy of the proposed plan and were requested to serve on an organization committee for their county: The county judge to act as chairman; the county health officer or nurse; a member of the County Medical Society; and a member of the Masonic Order. If these individuals were unable to serve actively, they were requested to designate an interested person or members of a local organization. Local permanent county committees were then formed. In many instances the original group is still actively serving as a committee.

A Mobile Unit and the necessary additional equipment was obtained. A one-half ton panel type truck serves adequately to meet requirements. The truck body is lined with insulation. In back of the driver's seat a built-in ice box has been constructed. The center compartment holds seventy-five pounds of ice. The two side compartments contain six removable metal trays with metal separators each to hold twenty donor bottles. The trays are so arranged to allow air space for cooling. The total capacity is 120 bottles. Along each side of the truck are built-in cabinets for supplies and powdered plasma. The larger cabinet was designed to be covered with a mat and the truck may be used as an ambulance to transport an injured person. A stretcher and fracture splints are carried for use in emergencies. The truck carries all supplies, donor bottles, donor sets, syringes, alcohol, iodine, novocain, and equipment to wash out the donor tubing. All equipment and donor sets are prepared at the Blood Bank, wrapped and sterilized. The regular personnel of the unit consists of a driver and a registered nurse who does the bleeding.

The permanent county committee is the "Heart of the Organization." The success of the state program depends entirely on the efforts of its members.

The following discussion gives in a general way how the program is operating: The County Committee appoints a custodian and designates a place of storage for the plasma. A date for the mobile unit is requested from the executive secretary at the Medical School. When a date is confirmed, local donors are registered and given appointments at regular intervals during that day. Arrangements are made for a suitable bleeding center such as the Community House, a school, the Masonic Lodge, or American Legion Post. Six to eight cots or beds are provided for the donors and two chairs or a chair and a small table for the donor equipment is with each cot. Local physicians are scheduled to be present during the day of the mobile unit visit to be responsible for rejecting questionable donors and to care for any accidents, reactions, or syncope of the donors.

The following volunteer non-professional help is appointed to serve at the bleeding center: A receptionist to greet and direct the donors as they arrive. Two clerical helpers to fill out donor cards, acknowledgment cards, and to print the donor's name on the donor bottle and Wassermann tube labels. Two or more persons to prepare and serve refreshments to the donors. Only black coffee or soft drinks are served before

donation, and milk, coffee, fruit juices, crackers, sandwiches or cakes after the donors have given their blood. An aide for each donor cot to keep the donor bottle in motion during the bleeding and to help with the equipment. Two persons (Boy Scouts have been unusually satisfactory) to wash donor equipment after use and to carry full donor bottles to the ice box in the truck.

After the day's bleedings are completed the nurse in charge of the mobile unit leaves one unit of powdered plasma and its companion bottle of water, in individual cardboard containers, for every two full bottles of donor's blood. This return of one unit for two donations is to build up the reserve at the Blood Bank and to take care of any losses through positive Wassermanns, breakage, or in processing. The plasma is left in care of the county custodian. With each unit of plasma is a "release card" to be mailed by the custodian to the Blood Bank with the name of the physician requesting the unit. Each unit of plasma has a "report card" to be filled in by the physician using the plasma stating the patient's name, indication for its use, and if any reactions occurred. To provide confidential information a self-addressed envelope is provided with the report card. The question of the patient's ability to pay a laboratory fee of either \$5 or \$10, or if no charge is to be made, is left entirely to the physician.

Each county is left one complete "giving set" with instructions as to the means of regenerating desiccated plasma. This set consists of an air vent needle, eighteen inches of intravenous tubing with a large needle to pierce the plasma bottle at one end, a filter drip in the upper end of the tube, a glass adapter and an intravenous needle for the recipient at the lower end. A double transfer needle is provided to allow the distilled water to flow into the powdered plasma bottle. Any additional sets or replacements are to be furnished by the local group.

The mobile unit returns the whole blood to the Blood Bank for processing after return of Wassermann reports.

The State of Arkansas Blood Products Program has as its ideal to make available to every citizen of the state of Arkansas blood plasma and blood products regardless of color or economic status. In order to realize this ideal the following objectives are necessary:

To increase the capacity of the present bank and processing plant.

Increase the Blood Bank and mobile unit personnel.

To increase public interest by posters, talks to

local groups and moving picture shorts.

To have demonstrations, lectures, and clinics to physician groups throughout the state to promote and encourage the use of blood plasma and blood products to improve the care of patients.

To have an interested group of the Medical School faculty study present methods and improvements in the treatment of shock and burns and to distribute information to the physicians throughout the state by circulars and demonstrations.

To have available as soon as practical, whole blood type "O" for transfusions, and resuspended red blood cells.

To process "leucocytic cream" powder and desiccated red blood cells for treatment of ulcers and infected wounds.

To develop a convalescent serum center for state distribution.

To provide every county with an adequate supply of powdered plasma, available to any licensed physician.

To provide every actively practicing physician a supply of plasma, particularly in the rural districts, to carry in his car for emergency cases in the patient's home or at the scene of an accident.

To build up a "catastrophe reserve" of frozen plasma at the Medical School of at least 2,000 units for state-wide use.

To maintain an organized "disaster unit" of physicians and nurses at the Medical School to be available when requested in the state. This unit to carry plasma, first aid equipment, stretchers, splints, and bandages to help the local physician with the immediate care of the injured.

Up to the present date, October 21, 1944, the Blood Bank has distributed throughout the state over 1,400 units of plasma. The future of this program will depend on the demand by the Arkansas physicians.

COMMUNIQUE

October 25, 1944.

To the Editor:

Greetings from ** to you and the "Home Front Medics." Keep up the good work on post-war medicine as we are damn interested in the medical future of our country. The above is the first release of my division's efforts and if you can read between the lines, you can see we medics are very busy. Please remember me to the Arkansas Medical Society.

J. O. Boydstone,
Lt. Col., M.C.

THE SEVENTH ANNUAL FORUM ON ALLERGY WILL MEET IN PITTSBURGH, PENNSYLVANIA

The Seventh Annual Forum on Allergy will be held in the Hotel William Penn, Pittsburgh, Pennsylvania, on Saturday and Sunday, January 20-21, 1945. This is a meeting to which all reputable physicians are most welcome, and where they are offered an opportunity to bring themselves up to date in this rapidly advancing branch of medicine by two days of intensive post-graduate instruction. For instance, the twelve study groups, any two of which are open to him, are so divided that those dealing with ophthalmology and otolaryngology, pediatrics, internal medicine, dermatology and allergy run consecutively. In addition, the study groups are arranged on the basis of previous registration. In this way, as soon as the registrations are completed, the registrant is expected to write the group leader and tell him just what questions he wants brought up in the discussion. Attention is also called to the fact that during these two days almost every type of instructional method is employed. Special lectures by outstanding authorities, study groups, pictures, demonstrations, symposia and panel discussions.

For further information, copies of the book and registration, write Jonathan Forman, M. D., Director, 956 Bryden Road, Columbus 5, Ohio.

COMMUNIQUE

U. S. Naval Hospital,
Fort Eustis, Virginia.

To the Editor:

I ask your tolerance of my negligence in reporting change of address. Have appreciated the Journal and news letters greatly.

Spent two years in T. H., landed in these good states on September 29th and had 15 very short days during which I appreciated seeing most of the Craighead-Poinsett group. The time was all too short and being home that short time sure stirred the old longing to get the thing over with and get back.

Jack Agar is here and I hear Calcote is supposed to report here soon.

My gratitude for all your kindnesses.

Sincerely,

E. R. Barrett,
Lt. Comdr., M.C., USNR

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

THE danger than an unsuspected case of tuberculosis will infect others is present wherever human beings live in close contact. Whether it be in families, in schools, in offices, or under such artificial conditions as were produced by the evacuation of children from the danger areas in England is not important—the significant factor is always the case which is not recognized until too late to prevent spread of the disease. Too often children are overlooked in the search for contacts when a case of tuberculosis is discovered.

PULMONARY TUBERCULOSIS AS INFLUENCED BY WARTIME RELOCATION

An increase in tuberculosis in England following the outbreak of the war seemed to justify collection and examination of the results of work among tuberculous children in East Sussex in relation to the spread of the disease traceable to evacuation and billeting.

Little work has been done in England on locating the source of tuberculosis observed among children. Reports from Scandinavian and American investigators show that wherever the background of these children is carefully studied, large numbers of unsuspected spreaders of bacilli can be detected among their contacts, since infection quickly registers among children exposed to open cases of tuberculosis. This has been demonstrated by our experience with evacuated children.

Method of Investigation

History, physical examination, tuberculin skin tests, blood sedimentation rates and chest X-ray films were recorded in all cases. Gastric lavage was done on cases admitted to the hospital.

Case Histories

GROUP I—Cases showing the effect of billeting healthy children with others who have open tuberculosis:

Case 1. A girl 12 years old was admitted to the hospital with a diagnosis of rheumatism. She was found to have a cough of several months duration but previous examinations made in London had proved negative for tuberculosis. Therefore, the tuberculosis office of the reception area had not been notified. Cavities were found at

both apices. This was confirmed by X-ray. The blood sedimentation rate was 21 mm; later it was 50 mm; the sputum was loaded with tubercle bacilli.

School Contacts—Four children out of fifteen were found to be infected with tuberculosis. Two others showed suspicious X-ray findings. All children were re-examined at three-month intervals until calcification developed in the primary foci and mediastinal glands.

Billet Contacts—A girl six years old was infected by Case 1 who was billeted with the parents of Case 2 for six months during which time the child developed a cough. She had a pleural effusion in the right base demonstrated by X-ray. The primary complex appeared as this cleared. The child made a good recovery with healed calcified lesions in the right lung appearing later.

Another contact was an eight-year-old girl who was admitted to the hospital complaining of abdominal pains. She gradually developed tuberculous meningitis and died after three weeks. X-rays showed miliary tuberculosis. She spent a month with Case 1 at a holiday camp, sharing a bed with her at this time.

Case 2. A boy 11 years old was sent to the local practitioner because he looked thin. The doctor found suspicious signs in his chest and sent him to the hospital. The school medical officer had examined this boy with special attention because his mother had died of tuberculosis

but did not X-ray his chest. No note had been sent to the tuberculosis officer of the reception area. There were cavities at both apices, confirmed by physical signs. Gastric lavage showed many tubercle bacilli. In addition to the boy's mother, a brother and a sister in the same family died with tuberculosis and the child himself had attended a tuberculosis clinic.

School Contacts—In all, 40 children and their teacher were examined and 11 of them were found to have been infected with tuberculosis; six of these showed definite activity, four had healing lesions and one had a calcified lesion.

Billet Contacts—Case 2 was billeted with five other children, three of whom were infected with tuberculosis. One child in this group had sanatorium treatment.

GROUP II—The effect of billeting healthy children in households in which there is or has been tuberculosis is no less serious:

This is illustrated by the case of a child of five who entered the hospital with phlyctenular conjunctivitis and was found to be infected with tuberculosis. She was one of six brothers and sisters, all previously healthy, who were placed with a foster-mother known to have had tuberculosis eight years previously. This woman had a bad cough while the children were living with her but refused examination. Four of the six children were found to have tuberculosis.

GROUP III—Neglecting the examination of child contacts may also have disastrous results:

Case 3. A girl six years old died in the hospital of miliary tuberculosis. The child was infected by her aunt, a young adult who had entered a sanatorium some months before. The child had often visited her but had not been examined and the tuberculosis officer in the reception area had not been notified.

School Contacts—Case 3 attended an evacuated school and all of the children, 39 in number, and three teachers were examined. Eight children had evidence of recent tuberculous infection.

Two of the children examined with this school were found to have tuberculosis. The infection in the case of these two was traced to their mother, who had died from tuberculosis four months earlier. After the death of the mother one child had been exam-

ined clinically but no X-rays were taken.

Billet Contacts—A brother and a cousin, the latter of whom died of tuberculous meningitis, were found to be infected. Another brother has remained healthy.

Discussion

In reviewing these cases one is impressed by the importance of the search for child contacts and the little attention usually paid to them. So great is the risk of bacillary transmission that all children who have been in close or repeated contact with a case of reinfection pulmonary tuberculosis should be regarded as having become infected until it is proved otherwise.

To be domiciled with a case of open phthisis is relatively much more dangerous than to attend the same school with a case. Physical examination that deals with the exterior of the chest alone is worthless in children and may be dangerous, as an infected child may be labeled as "normal." All child contacts should have complete examinations, including tuberculin skin tests and X-ray examinations.

Wherever children are placed in a new environment, great care should be taken to establish that they are not suffering from tuberculosis and that they are not thrown unwittingly into contact with it. Certainly, a more intensive search must be made for all child contacts of open cases of tuberculosis.

Pulmonary Tubercle in Children, Influence of Evacuation on Its Incidence, Marcia Hall, M.D., *The Lancet*, July 10, 1943.

COMMUNIQUE

October 26, 1944.

To the Editor:

I have continued to get your welcome communications, such as "Random Thots" and the letters from Drs. Jones and Mahoney and Mr. Dudley, although my address has been changed. I was sent here when the old Arkansas 153rd Infantry was inactivated. The inactivation was a not very fitting end to an outfit that did work horse's share of the tough part of the Aleutians campaign. Looks like I'm going to get another smell of salt sea air, this time in the direction of the krauts.

Best regards.

C. Lewis Hyatt,
Capt., M.C.,
301st Med. Bn.,
Camp McCoy, Wis.

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EDITORIAL

ARMY DISCONTINUES THE RECRUITMENT OF CIVILIAN PHYSICIANS

"Paul V. McNutt, chairman of the War Manpower Commission," The Journal of the American Medical Association for November 4 reports, "announces that he has been informed by the War Department that recruitment of civilian physicians for the Army has been discontinued. At the same time he announces that recruitment for the Navy must continue, since it has urgent need for approximately 3,000 additional medical officers. The U. S. Public Health Service and the Veterans Administration are also continuing to recruit physicians, Mr. McNutt said.

"Vice Admiral Ross T. McIntire, chief of the Bureau of Medicine and Surgery, U. S. Navy, informed Mr. McNutt that personnel expansion and intensification of operations in the Pacific have precipitated a grave shortage of medical officers.

"With less than 13,000 medical officers on active duty in the Navy, the procurement of at least 3,000 more as soon as possible is imperative," said Admiral McIntire. "Even this figure will not meet actual needs but would ease the

emergency that now exists; physicians and surgeons whose availability has been or may hereafter be certified by the Procurement and Assignment Service, WMC, should lose no time in obtaining particulars for commissions in the Navy Medical Corps by communicating with their nearest office of Naval Officer Procurement."

"Mr. McNutt said he had been informed that the Army will fill its future requirements for military physicians from sources now available to the Army and thereafter will not require certification of availability of additional physicians from the Procurement and Assignment Service of the War Manpower Commission. There are now about 47,500 physicians on duty as medical corps officers of the Army. This probably includes those serving with the Veterans Administration and other governmental agencies to which the Army Medical Corps assigns its medical corps officers.

"Mr. McNutt said that there are at present roughly 60,000 physicians in the armed forces and the Veterans Administration. The total number of physicians in the armed forces represents approximately 40 per cent of the active medical profession of the United States.

"In addition to the 3,000 medical officers needed at present by the Navy, the Public Health Service has need for approximately 300 for the U. S. Coast Guard and other agencies.

"In informing Mr. McNutt of the termination of the Army recruiting of physicians except for the occasional specialist, Maj. Gen. Norman T. Kirk, Surgeon General of the Army, said, 'The large number of physicians now in the Army volunteered for commissions without regard for their personal interests. The U. S. Army Medical Department is appreciative of the fine service they have given. Their removal from their usual practice also represents a sacrifice on the part of all civilians, who have had to get along with less medical care than they obtained in peacetime.'

"The Veterans Administration has, and will continue throughout the duration of the war emergency to have, assigned to it medical officers in the Army and the U. S. Naval Reserve to care for the needs of the casualties in its charge, the War Manpower Commission said. Doctors whose applications are at present in process for appointment in the Army Medical Corps will be considered for appointment and assignment to duty with the Veterans Administration, the War Manpower Commission statement added.

"Mr. McNutt said that the War Manpower Commission joins with the directing board of its Procurement and Assignment Service and the War Department and the Office of the Surgeon

General in expressing appreciation of the sacrifice involved in cooperation that was necessary on the part of physicians and the public before the Army reached its present level of medical personnel.

"Mr. McNutt also expressed the hope that additional civilian physicians will respond to the Navy's appeal for more doctors to apply for commissions. The needs of the U. S. Public Health Service and the Veterans Administration, he said, although much smaller than those of the Navy, are nevertheless important."

PHYSICIAN VETERANS' EDUCATION IS PROVIDED FOR BY G. I. BILL

Doctors in Service Are Entitled to Receive Graduate Training Under the Provisions of the Law, A. M. A. Committee Reports

Physician veterans of this war are eligible to obtain graduate education in the post-war period under the provisions of the so-called "G. I. bill," which entitle them to payment of tuition and also a subsistence allowance while taking their courses, a conference with officials of the Veterans Administration has disclosed, it is reported in The Journal of the American Medical Association for November 11th.

The information, which, as The Journal points out in the same issue, is of the "greatest importance to all physicians now serving with the armed forces," is contained in a preliminary report of the Subcommittee on Post-War Education of Physician Veterans, of the American Medical Association's Committee on Post-War Medical Services.

The Journal further emphasizes the importance of the report by pointing out that "Preliminary reports on the results of the questionnaire sent by the Committee on Post-War Medical Service to all physicians in the armed forces indicate that the majority of physicians wish graduate education, including short and long courses, in the post-war period."

The report points out that it was the opinion of the official in charge of the administration of that phase of education of veterans that the approved schools and hospitals in which the physician veterans would be taking their graduate training can be regarded as institutions eligible for recognition as educational centers in which such educational benefits might be provided under the law.

The conference brought out the fact that the

law, as interpreted, makes it possible for any physician now in any of the branches of the service and who has been on active duty for more than ninety days to be eligible for any of the benefits provided by the law.

In addition to the tuition and fee benefits provided under the law, physicians coming under the provisions of the act also will be paid a subsistence allowance of \$50 per month if without a dependent or dependents or \$75 per month if he has a dependent or dependents.

The tuition and fee benefits and the subsistence allowance for physicians engaged in such courses will be subject to limitations which depend on the duration of service and similar factors.

TRANSCRIPTIONS FOR HEALTH BROADCASTS

The Bureau of Health Education of the American Medical Association offers a new service to county and state medical societies having difficulties in keeping up radio broadcasting to the public because of shortage of personnel. Scripts to be read by local doctors or used as a basis for new or rewritten material prepared locally have been available for many years and may still be had. In order, however, to meet the local personnel shortages, the bureau has now prepared several series of electrically transcribed radio broadcasts available to state and county medical societies and auxiliaries or to local groups approved by the state or county medical societies. These broadcasts may be used with a minimum of time-consuming local preparation and participation.

At the present time, four series are available for broadcasting to the public and one series for use in connection with health teaching in elementary schools. The blue circular that accompanies this bulletin lists the series of broadcasts available and indicates the method of procuring them, namely, by borrowing complete sets from the Bureau of Health Education without expense to the local society except the nominal cost of shipping the platters back when they have been used.

The distinction between the two types of transcriptions offered should be noted. The series intended for broadcasting direct to the public are available on loan. One series entitled "Health Heroes" for use in schools is offered for sale only because it is necessary for a school to own these records in order to make the best use

of them. The price is \$25 per set of 12 programs on six two-sided 16-inch records. In order to use them in schools, one of two arrangements must be made: (1) the school must have a central record playing instrument with loud speakers in classrooms or a portable record player; or (2) arrangements must be made with the local radio station to play these records at a convenient time and radio receiving sets must be supplied to the classrooms. These teaching helps will fit in curriculum. The scripts furnished enable the teacher to become familiar with the program in advance and thus make the best possible use of it in her teaching. Orders for these records should be accompanied by a remittance or official purchase order from the local board of education. Local medical societies or auxiliaries might wish to purchase sets of these records for presentation to the schools as an act of cooperation and evidence of good will.

WHEN WE EXAMINE, LET'S DO A REAL JOB

Now that the government has become so keenly interested in the subject of physical fitness, we will hear more and more about reasons for and the merits of a periodic health examination. Certainly such examinations will play a big part in any or all physical fitness programs.

In reflecting, we have to admit the sad truth that the medical profession has never given as much support to periodic health examination programs as such procedures deserve. Periodically here in Ohio there has been a revival of such programs but they have never actually clicked. Now is the time for Ohio physicians to turn over a new leaf. We should prepare for demands which will be made upon us as soon as the physical fitness program gets into full swing.

Three points about the periodic health examination should be very clear to us:

First, we should realize that by a very simple but complete going-over, a physician can detect in a patient a goodly number of gross defects, not even suspected by the person examined. Among these defects are such things as diseased tonsils, decayed teeth and pyorrhea, allergic rhinitis, gross impairments of vision, bad posture and flat feet, hernias or enlarged rings, heart murmurs and disordered heart action, goiter, and sugar in the urine. Some of these can be corrected. Where this is true, their correction will not only add to the efficiency of the individual but will, on the average, give him six additional years of life.

Unfortunately, those who want to get these potential patients into our offices are disturbed frequently because of the casual way in which some physicians make these investigations. These check-ups are not too complicated and do not take an unusual amount of time. A little more effort on the part of all physicians along this line would yield big returns in terms of public health, of more public confidence in the profession as a whole, and an increased clientele for more physicians.

Second, we should understand that almost all of the defects which have been mentioned are the result of poor nutrition coming largely from bad food habits. So, if we want to do away with them and with the expense of these examinations (and they will be very expensive to the taxpayer if the Federal Government sets up "examining centers"), we must continue the campaign to improve the nutrition of our people.

This nutritional campaign, if properly carried out, can make a great contribution to post-war economics. For example, do you know if every child under 14 years of age in this country were to get one quart of milk each day, that it would require more than 10 million additional cows, one million additional farm laborers, and the return of more than 40 million additional acres of farm land to production?

Third, physicians have neglected themselves badly in recent years. Many are pretty well worn out and physically unfitted to carry on present schedules. A fine contribution to the physical fitness program which physicians could make would be to get checked up themselves. Society has a right to ask that we do so, as society in the end has a big investment in us. Therefore, we owe it to ourselves, our families and to the public to lead in this campaign for the partial rehabilitation of defective and worn-out citizens by practicing good preventive medicine on ourselves. Let someone else do the preaching.

—The Ohio State Medical Journal, September, 1944.

\$34,000 IN WAR BONDS AS PRIZES

for the best art works by physicians, memorializing the medical profession's "Courage and Devotion Beyond the Call of Duty" (in war and in peace).

This prize contest is open to any physician member of the American Physicians Art Association, including medical officers in the armed forces of the United States and Canada.

Full information available on request of the sponsor, Mead Johnson & Co., Evansville, Ind., U.S.A.

RANDOM THOUGHTS OF THE SECRETARY

October 12th. Buying gasoline in the new manner at Conway this afternoon where, after many years of filling up the car tank, this afternoon we put it in the aeroplane tank and again take off across Faulkner, White and Jackson counties into Craighead where the good government has left Jonesboro supplied with an unused, first class airport, neglecting only to furnish taxi strips to the runways. Meeting with the First Councilor District Society tonight, which we have done for one-seventh of their total meetings and enjoying the occasion as always. Particularly delighted with the praise heaped upon the ladies of the Auxiliary for the flowers by the visiting men from Memphis, whose assumptions in this regard did not consider that the club hostess may have done the arranging.

October 13th. In the early morning hours returning from Jonesboro and as we cross Petit Jean to see this table land in new view, we wonder if Hardison has ever flown over this park and recreational empire of his.

October 18th. The El Dorado Daily News carries a front page story of the Fifth Councilor District Medical Society with the opposition of Governor-Elect Laney to the Hollingsworth Act well presented—an example to the rest of us and evidence that acting secretary White did the job well.

October 27th. Briefly visiting the Stover establishment this afternoon finding the staff enjoying a new gadget, the leather embossing apparatus, on which Bill drops the "i's, perhaps nothing new for Bill to misplace his eyes, except when selecting Christmas cards for our colleagues in service. On to Brinkley where a small group makes the Third Councilor District Society meeting but enthusiasm is high and the program exceptional. Back to Little Rock with Fred Hames who fully observes the wartime speed limit and thence homeward, the radio giving full prominence to "Anchors Aweigh" as the hit song of the evening as we thoughtfully salute our 23 colleagues wearing the blue and on its 169th anniversary. Thank God for the United States Navy.

November 2nd. Now we begin to put together some of the expressed thoughts of our colleagues from the China-Burma-India theater and our impressions become a bit more clear as to confusion which must exist at the "end of the line."

November 5th. Arriving Huron, South Dakota, where one is reminded of Stuttgart and Gillett although all the talk here is of upland game birds—the famous pheasant—and little regard is given to many mallards seen in the sky.

November 6th. Initiated into the mysteries of pheasant hunting, finding that beautiful bird the fastest on ground or air that we have seen—it seems that in flight you lead him by about ten feet if you get a shot to count. Rain and fog dampen the body but not the spirits and we return with the dark counting 19 out of a possible 20 bag limit.

November 7th. Watching the intense enthusiasm of this Republican stronghold as the voters gather into the polls and we know better now how a Republican feels in Arkansas on election day. But pheasants continue to absorb our greater attention our vote having been cast last week and we cover the county with no inducement from the weather.

November 8th. It may be "The Day After Forever" but partisanship is now past and all of us should work for the greater good of this country of ours.

November 9th. With clearing skies we observe more

closely the South Dakota countryside, forlorn and lonely, flat prairies, constant winds, widely scattered homes, all showing by their weather-beaten appearance that lean years have been their lot. All too often comes the deserted farm whose owner has finally given up the effort and moved away with his few personal possessions to try again in a more hopeful environment. Yet those who remain evoke your sincere praise for a steadfastness which must try the strongest souls.

November 10th. In a hunter's paradise today catching up on the bag limit shortage and coming out exactly even as day is done and departing for home with some question whether it is youngster or oldster who has had the most fun. This marking the youngster's graduation from sparrow shooting with a BB to big-time stuff, it is proper that his first pheasant cock and the last hen, which closed the season for the two of us, should be mounted to add to the varied decorations of his room.

COMMUNIQUE

August 22, 1944.

To the Editor:

I'm always glad to receive a copy of the Journal each month. It helps to keep me informed on the "whereabouts" of some of my past associates. Recently I came across Capt. Jack Reynolds, who is with a portable surgical hospital, and Maj. Freidman Cisco, who is with an evacuation hospital in this area. I have been overseas since September 25, 1943, with a signal battalion.

Best wishes.

Sincerely,

W. J. Stocker,
Captain, M.C.

OBITUARY

CAPT. WILLIAM M. KOBER, age 32, Medical Corps, Army of the United States, Little Rock, was killed in action in France August 29th. Born in Little Rock March 16, 1912, he attended Little Rock public schools, Columbia University and Yale University School of Medicine, from which institution he received his medical degree in 1938. He served an internship at Lennox Hills Hospital in New York City and had practiced medicine in Little Rock for two years prior to his entry into military service in August, 1941. Serving with the Fourth Cavalry in this country, he was subsequently assigned to the Reconnaissance Squadron, Twenty-fourth Cavalry, overseas. Dr. Kober is the first member of the Arkansas Medical Society to lose his life in this war. Surviving relatives are his wife and three children.

PROCEEDINGS OF SOCIETIES

The Craighead-Poinsett County Medical Society met in dinner session at Jonesboro November 2nd for the following program: "Industrial Medicine," O. V. Smith, Trumann, and "Ectopic Pregnancy," H. H. McAdams, Jonesboro.

J. H. McCurry, Secretary.

The Sebastian County Medical Society was addressed November 14th by Lt. Col. Jos. Goodman, Camp Chaffee, on "Blood Cultures in Relation to Otitic Sepsis."

D. W. Goldstein, Secretary.

The Benton County Medical Society met in dinner session at Siloam Springs November 9th for a presentation of unusual cases by the physicians of that city.

Geo. M. Love, Secretary.

The Southeast Arkansas Medical Society met at McGehee recently for the following program: "Osteomyelitis," Jos. F. Shuffield, Little Rock, and "War Medicine," Lt. Comdr. T. P. Foltz, Fort Smith. Chas. W. Dixon, Gould, was re-elected president.

Prairie County Medical Society has elected the following officers: President, Edward Adams, DeVal's Bluff; president-elect, J. R. Lynn, Hazen; vice-president, W. H. Crockett, Biscoe; secretary-treasurer, J. C. Gilliam, Des Arc; delegate, J. C. Gilliam, and alternate, Edward Adams.

The Third Councilor District Medical Society met at Brinkley October 27th for the following program: "The Spastic Child," Pat Murphey, Little Rock; "Penicillin in the Treatment of Osteomyelitis," Jos. F. Shuffield, Little Rock; "Hemorrhage in the New Born," J. O. Rush, Forrest City; "X-Irradiation in Non-Malignant Conditions," Fred Hames, Pine Bluff; and "A Plea for Conservatism in the Management of Acute Cardiac Crises," A. F. Barr, Cherry Valley. The Society met in informal dinner session at the conclusion of the scientific program.

J. O. Rush, Secretary.

The First Councilor District Medical Society met in dinner session at Jonesboro October 19th for the following program: "Penicillin in the Treatment of Osteomyelitis," Jos. F. Shuffield, Little Rock; "Cardiac Neurosis," Neuton S. Stern, Memphis, and "Cancer of the Large Bowel," J.

L. Jelks, Memphis. O. T. Cohen, Jonesboro, was elected president and Earle D. McKelvey, Paragould, was elected vice-president.

J. H. McCurry, Secretary.

CORRESPONDENCE

HEADQUARTERS 4TH CAVALRY GROUP, MECZ
APO 230, care of Postmaster
NEW YORK, N. Y.

October 23, 1944.

Mrs. Ethel May Kober,
624 Valmar Street,
Little Rock, Arkansas.

My dear Mrs. Kober:

Undoubtedly by this time you have received the sad news of your husband's death through official channels but I would like to offer my own heartfelt sympathies to you and to tell you something of the circumstances in the hope that it might be of some comfort to you.

During the daylight hours of the 29th of August while going to the aid of a seriously wounded enlisted man, the half track in which Captain Kober and two of his medical aid men were riding, received a direct hit from an enemy gun. The ambulance was plainly marked with the Red Cross. Captain Kober and his two assistants were instantly killed and the half track ambulance was destroyed.

Up until the time of his death "Bill" had done a superior job as Squadron Surgeon and he was respected and admired by every officer and enlisted man who came in contact with him. Along with his excellent professional qualifications, he was endowed with a cheerful and friendly disposition which materially aided his patients on the road to recovery. "Bill" was a wonderful guy and I know you and the kids will miss him just like all of his friends in the 4th Cavalry will.

His remains rest in an American cemetery in France. For detailed information as to the exact location of the grave, disposal of personal effects, etc., may I suggest that you write direct to the Quartermaster General, ASF, Washington, D. C., as they have all of those facts and I do not. However, please feel free to call upon me for any assistance.

In behalf of all the officers and men of the 4th Cavalry I extend our heartfelt sympathy.

Sincerely yours,

J. M. Tully,
Colonel, 4th Cavalry Group,
Commanding.

HAVE YOU CASHED ANY BONDS LATELY?

An American soldier in a sniper's post on a Jap-infested island in the South Pacific had been doing his job and doing it well. Suddenly, his superior officer whispered from behind him: "Buddy, you'll have to give me your rifle." "Why?" inquired the sniper, "I've been doing all right. In the past five hours I've picked off nineteen of the yellow Nips; why must I give up my gun now?" "I hate to tell you," said the officer, "but the fellow back home whose War Bond purchase paid for the rifle wants his money back."

PERSONAL AND NEWS ITEMS

Capt. Doyle L. Patton, El Dorado, is now on duty with the 1914th Service Unit, Ford Worden, Washington.

Capt. Joseph S. Smith, Little Rock, is now stationed with a general hospital overseas.

Capt. Earl J. Bieri, Hot Springs National Park, is now stationed with the Army Air Forces at Orlando, Florida.

Otis G. Hirst, Prescott, now stationed overseas, has been promoted to lieutenant colonel.

Ralph E. Crigler has been elected president of the Junior Chamber of Commerce at Fort Smith.

Capt. O. B. McCoy, Harrison, has received the Distinguished Unit Citation ribbon.

R. L. Armstrong has been elected surgeon of the Stamps post of the American Legion.

W. J. Ketz has been elected president of the Batesville Kiwanis Club.

Lt. Huie Haskell Smith, Little Rock, is now stationed overseas.

"Management of Certain Types of Fractures Involving the Shaft of Long Bones" by F. Walter Carruthers, Little Rock, appeared in the November issue of the New Orleans Medical and Surgical Journal.

The following scientific exhibits were presented at the St. Louis session of the Southern Medical Association: "Pathological Lesions in the Brain in Malaria" by D. E. Fletcher and R. H. Rigdon, Little Rock, and "The Arkansas State Blood Plasma Program," by Paul C. Eschweiler, Little Rock.

Chas. T. Chamberlain, Fort Smith, opened the discussion of Wm. Kendrick Purk's paper, "Carotid Sinus Syndrome" at the St. Louis session of the Southern Medical Association.

R. H. Rigdon, Little Rock, presented "The Pathological Lesions in the Brain in Malaria" before the Section on Pathology at the St. Louis session of the Southern Medical Association.

Capt. C. G. Leverett, Eudora, is now stationed at Brooke General Hospital, San Antonio, Texas.

Lt. Col. J. W. Branch, Hope, has been awarded the Bronze Star Medal for meritorious achievement in military operations against the enemy.

Capt. Gerald Blankfort, Little Rock, is now on duty at the AAF Convalescent Hospital, Fort Logan, Colorado.

Lt. John P. Eaton, Little Rock, is now stationed at Abilene, Texas.

Maj. Hugh Mobley, Searcy, is now hospitalized at Dibble General Hospital, Menlo Park, California.

Lt. Comdr. E. R. Barrett, Jonesboro, is now stationed at Naval Hospital, Fort Eustis, Virginia.

Lt. Jack Agar, Little Rock, is now stationed at Naval Hospital, Fort Eustis, Virginia.

D. W. Goldstein, Fort Smith, attended the recent Venereal Disease Conference of the United States Public Health Service held in St. Louis.

H. E. Murry, Texarkana, attended a traumatic surgery and fracture course at Tulane University during November.

Capt. James L. Pickens, Bentonville, is now stationed with the 172nd General Hospital, Brigham, Utah.

Capt. R. D. Dickins, Monticello, is now stationed at the Army Air Field, Big Springs, Texas.

Lt. Jack W. Kennedy, Prescott, is now stationed with the 127th Evacuation Hospital, Camp Bowie, Texas.

Julius B. Askew, United States Public Health Service, Little Rock, is now stationed at Burbank, California.

Capt. Art B. Martin, Fort Smith, is now on duty with Medical Detachment, 901st Field Artillery Battalion, Camp McCoy, Wisconsin.

Capt. Earl J. Bieri, Hot Springs National Park, is now stationed with the AAFSAT at Orlando, Florida.

Capt. Hugh W. Savage, Little Rock, is now

stationed with the ATC, Washington, D. C.

L. L. Fatherree, Little Rock, addressed the Arkansas Restaurant Association October 30th on "Our Public Health Problem."

Maj. Elmer J. Ritchie, North Little Rock, is now stationed overseas.

Clarence F. Watson, Little Rock, has moved his office to 904 Donaghey Building.

C. M. Harwell and L. D. Massey have been elected stewards of the Osceola Methodist Church.

James T. Rhyne, Little Rock, has been appointed Lieutenant, Medical Corps, Army of the United States, and ordered to active duty.

A. S. J. Clarke has moved from Conway to Fort Smith where he is associated with the Cooper Clinic.

Lt. Col. J. O. Boydstone, Hot Springs National Park, is serving as division surgeon for an armored division overseas.

Fred Hames, Pine Bluff, has been appointed Arkansas chairman for the American Cancer Society.

F. Walter Carruthers, Little Rock, recently attended the Clinical Orthopedic Society meeting in Milwaukee.

Capt. Cyril Lewis Hyatt, Little Rock, is now stationed with the 301st Medical Battalion, Camp McCoy, Wisconsin.

Maj. Jerome S. Levy, Little Rock, is now assigned to Letterman General Hospital, San Francisco.

"Torson of Ovarian Cysts in Children" by Ruth Ellis Lesh, Fayetteville, appeared in the June, 1944, issue of the American Journal of Obstetrics and Gynecology.

W. H. Calaway, Batesville, now stationed at Santa Maria, California, has been promoted to lieutenant colonel.

Maj. Julius H. Hellums, Dumas, is now stationed at the Atlanta Army Air Base, Atlanta, Georgia.

C. R. Chesnutt, Little Rock, attended the recent sessions of the American College of Physicians in Chicago.

COMMUNIQUE

October 17, 1944.

To the Editor:

I have never written a communique to the State Journal since I have been in the Army. Why I don't know unless I am just plain selfish and enjoy reading more than writing.

I left the good old U.S.A. February 19, 1942, and after roaming part of the Pacific, arrived in South America March 8, 1942. After about 27 months I returned to the U. S. May 2, 1944, arriving at my home May 7th. When I left home, my young daughter was only one day less than one year old. When I returned this year and found her almost 3½ years old, she was quite the little lady and no longer the baby.

My stay in Latin America was quite educational even if it was not all pleasant. I find they have both jungles and deserts, neither of which afford living conditions and surroundings as Hollywood likes to portray. There is plenty to knock the romance out of either place. It is certainly wonderful to be back and I sure hope I can have quite a long stay before I have to go out again.

You can't imagine just how much we fellows enjoyed the notes, letters and last, but not least, the jokes, which were mailed out by your office and various other medicos from home. When one would arrive it certainly was a highlight of the day or week. Army life becomes very monotonous under some circumstances as you can well imagine.

After a 21-day leave at home and having a little stay at the wonderful Redistribution Center at Miami, and waiting at another station for a while, I was finally given an assignment as Base Surgeon here at Atlanta Army Air Base, Atlanta, Georgia, and it's certainly wonderful to be able to get the day's work done and go home to the family at night.

I received my official election ballot today and on it I find printed one item which is quite shocking to me to say the least, namely, "Proposed Initiated Act No. 3—Hollingsworth State Hospital System Act." I read one write-up in our county paper a few days ago and from what I could digest it sounded to be quite a dangerous matter, potentially at least. I can't understand the distribution of the general hospitals and the county hospitals and just what these

county hospitals would do to privately-owned hospitals. It seems that the all-powerful commissions could state exactly what type of medical care would be given in these county hospitals. I know my own limitations and wish for my patients and I to decide just what type of medicine and surgery I can do when I revert to civilian life. I do not wish for a board of commissioners to tell me just what I can or can not do. However, if the competition of a "free county hospital" causes my little private hospital to close and I am too far distant from one of the general hospitals to use them, then the commissioners by limiting the work that can be done in the county hospitals, then its effect will limit the type of work I can do.

I hope I have mis-interpreted the bill and am unduly alarmed but from where I sit now it does not look good.

I would certainly appreciate it if you would write me giving me yours and the Society's reaction to the Act, before I mail my ballot in. At the present I would certainly vote against the bill but would feel badly if I voted against the act and found out later I was wrong about it all. I know that you and the Society have the dope. Will anxiously await your reply.

I can't figure out where this shortage of doctors in the Army exists. Maybe it does but there has certainly been an excess every place I have served. Other medics tell me the same.

Yours truly,

Julius H. Hellums,
Major, M.C.,
Atlanta Army Air Base,
Atlanta Munic. Airport,
Atlanta, Georgia.

COMMUNIQUE

September 27, 1944.

To the Editor:

Greetings and salutation from * * *. After a period of approximately four years, I shall take this opportunity to come out of my hermitage and express my deep appreciation for your newsy letter and the Journal. During this time, I have learned much about the medical systems used in England, France and * * *. I have tried to make a study of their systems so once upon my return to the United States, maybe the information I can make available to our society will assist in the future of the doctors of our country.

From your "round-robin" letter, I have been able to keep up with a large group of the doc-

tors who are now medical officers. I have only seen some three of them since I have been overseas: Captain Jack Ellis, Captain Carrington and Captain Max Hughes. I know the old saying about good intentions pave the way to hell and on this score, I am quite a sinner. I have intended writing many times, but due to rush and hustle, I have failed miserably. Please accept by apologies.

I am now stationed somewhere in * * *. Quite odd, the people here are more similar in mannerisms and mode of dress than any of the countries I have passed through. The doctors here have no trouble about clients, as there are only 186 doctors in the entire country.

I have lived in the fields so long that I have begun to get the typical country bumpkin hayseed odor. I have had my second bath in some sixty days, and much to my discomfort, I now have a cold. I will not try the bath ordeal again until the war is over.

At this time, I would like to reassure the doctors of the home front that the doctors of the battling fronts are holding up their end in such a manner that every person in the medical profession can feel duly proud of their fellow "over here." Sherman was right when he said, "War is hell."

Many of we pencil-pusher type of doctors are certainly going to need post-graduate or refresher courses after this is over. Though we are doing surprising things with the sulphanilamides and penicillin even here on the front lines, tragically we are unable to follow the course of the treatment in the rear.

I have tried to sell Arkansas from the sunny shores of California, the fog-swept streets and country roads of England, the hedgerows and apple orchards of France, the rambling hills of Belgium and at last, in the crazy-quilt patch fields of * * *; but I would not trade one pine tree on a small acreage in Arkansas for the entire rest of the world, I assure you.

Again I wish to thank you for the thoughtfulness in sending me the letters and Journals from home, and with the kindest personal regards to all my friends,

Sincerely,

Joseph O. Boydstone,
Lt. Col., Med. Corps.

COMMUNIQUE

October 18, 1944.

To the Editor:

Like most of us overseas, we don't have much

time for letter writing and when or if we do, don't have chair, desk or table—just sit on the edge of our bunk and write on our knee. So tonight, I sit in my tent and write with the paper on my knee.

I have wanted to write for some time but have not felt that I could say much of any interest to busy doctors back home. However, a couple of days ago, I met an Arkansas M. C. who is not a member of Arkansas Medical Society and has not received the Journal and Random Thots. It happened this way: I crawled out and went to chow line for breakfast. I noticed a strange major present; as I approached him he introduced himself and we began to eat side by side. He explained that he just happened to be passing by and saw we were about to eat—he had not had breakfast so he just stopped to eat. (You know a good soldier is one who never goes hungry). I asked where his home was—Hot Springs, Arkansas. Well, I replied, I am from Crossett, Arkansas. Oh, down where the pine trees grow tall, he said. It was like meeting someone from the old home town. In fact, he is the first Arkansas M. D. I have run into during my 16 months in service. It happened that I had, just the day before, received "Random Thots" for September, 1944. I asked if he had seen it. He had never heard of it before. He explained that he graduated in Little Rock in 1938, went to New York for internship and then a residency and then to the Army, that he had not had an opportunity to return to Arkansas and had neglected to join the Arkansas Medical Society. After breakfast I asked him to come to my tent and I would give him the copy, also the last copy of the Journal that I had received, August, I believe. He was really happy to get them and asked me to give his regards to all if I should happen to write to the Society. He is Maj. Thomas W. Williams, M. C., Commanding Officer, 606 Medical Clearing Company (Separate).

As for myself, I am okay and making it fine enough. This outdoors with rain, mud, colds, etc., is not so unusual for one from Ashley County, Arkansas, so I am able to keep up with the rest of my outfit, all city boys. I can still roll a blanket and sleep under any old tree as if I were on a hunting or fishing trip.

Faternally,

James H. Moseley,
Captain, M.C.

WOMAN'S AUXILIARY PAGE

Dr. D. W. Goldstein, guest speaker at a luncheon of the Auxiliary of the Sebastian County Medical Society November 14th, spoke on the "Relationship of Venereal Disease to Public Health."

The Auxiliary met at 12:30 o'clock for luncheon with Mrs. J. S. Southard hostess for the luncheon, and Mrs. B. L. Ware, Auxiliary president, presiding at the business session. Mrs. W. L. Shippey was enrolled as a new member. Mrs. J. S. Southard, program chairman, introduced Dr. Goldstein.

The next meeting of the Auxiliary will be held in January.

Mrs. W. F. Rose,
Publicity Chairman, Sebastian County
Medical Society Auxiliary.

Members of the Womans' Auxiliary to the Bowie and Miller Counties' Medical Societies were called on October 27th by the presidents of the Arkansas and Texas Auxiliaries to join in the fight against passage of the Murray-Dingle-Wagner bill which would set up a system of socialized medicine.

Mrs. A. C. Shipp of Little Rock, president of the Woman's Auxiliary to the Arkansas Medical Society, and Mrs. Sam E. Thompson, president of the Woman's Auxiliary to the Texas State Medical Society, were honored at a luncheon at the home of Mrs. N. B. Daniel, 908 Pine street, by the local auxiliary.

They told members of the local organization that they could do much to educate the general public about the dangers of the bill.

Both presidents pointed out that for the Auxiliary members to make intelligent arguments against the bill, they first must be thoroughly acquainted with its provisions and then use their influence and knowledge to the best advantage of the general public.

"We must educate the public as to the dangers and disadvantages of the bill to general health," the presidents said. They pointed out that the group could not be criticized for its opposition to the bill's passage on the grounds that it would reduce the income of doctors, because in fact, they said, the bill would increase the income of persons in the medical field. Despite this, they said, the wives of doctors should take an active part in trying to defeat the measure.

The presidents described the educational work being done in the two states under the sponsorship of the Auxiliaries, which are contributing

money to student loan funds and to libraries for the dissemination of knowledge concerning new medical practices to medical students and doctors.

Philanthropic activities in the two state organizations also were described, and the local organization was asked to help foster these projects.

Mrs. Shipp described an essay contest for students in the last two years of high school and in colleges which is being sponsored by the Arkansas Auxiliary as a means of educating the public in connection with the Murray-Dingle-Wagner bill. Topic of the essay to be written by the students was announced as, "A Menace to American Health." The Texarkana Auxiliary will sponsor the contest locally.

The value of the Medical Auxiliary work in education for improved general public health through the magazine "Hygeia," through public forums, and other educational work was favorably commented on by the presidents, who urged the Texarkana organization to continue its activities in this field with the slogan in mind, "Good health for citizenship."

In addition to the usual philanthropic and educational work which the organization carries on, plans for the year include additional service to the war effort through the War Activities Committee.

Mrs. J. T. Robison, president, was in charge of the meeting. She introduced Mrs. Shipp, and Mrs. Thompson was introduced by Mrs. H. E. Murry.

Hostesses with Mrs. Daniel for the annual luncheon honoring the state presidents were Mrs. S. A. Collom, Sr., Mrs. R. R. Kirkpatrick, Mrs. P. H. Phillips, Mrs. W. Lecker Smith, Mrs. C. H. Frank and Mrs. L. J. Kosminsky.

Mrs. Thompson, the Texas Auxiliary president, Mrs. Shipp, the Arkansas Auxiliary president, Mrs. Robison and Mrs. Hibbitts presided at the luncheon table.

The dining room and reception rooms were beautifully decorated with arrangements of dahlias, roses and other seasonal flowers.

Luncheon was served to the visiting presidents, Mrs. W. L. Kitchens of San Angelo, Texas, Mrs. William Daubs of Foreman, Ark., and the following members: Mrs. Roy Baskett, Mrs. Allan Colom, Mrs. Ralph Cross, Mrs. C. H. Frank, Mrs. William Hibbitts, Mrs. C. E. Kitchens, Mrs. Reavis Pickett, Mrs. J. T. Robison, Mrs. Joe E. Tyson, Mrs. E. M. Watts, Mrs. L. S. David, Mrs. G. I. Levine, Mrs. N. B. Daniel, Mrs. R. R. Kirkpatrick, Mrs. L. J. Kosminsky, Mrs. L. H. Lanier, Mrs. A. G. Lee, Mrs. H. E. Murry, Mrs. P. H. Phillips, and Mrs. W. Decker Smith.

Dear Auxiliary Members:

In these trying times, it is the duty of each member of this wonderful organization to do her very best to carry on and promote the work. The aims and ideals are the very highest and we are better women for striving to reach this goal.

Each Board meeting is an inspiration and we always come away fired with zeal to do better things.

As Organization Chairman for this year, I shall try to enlist new county organizations and members-at-large; also to re-enlist the counties that have suspended organizations. Having been members of the State Auxiliary, we hope to encourage them to come back into the fold. A chain is only as strong as the links, and when we lose a county that naturally weakens the chain. Each organized county is a vital part of the whole organization.

We must keep up the good work so that the members whose husbands are in the armed forces will be happy to return and take their places again.

Mrs. E. D. McKnight.

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A record of twenty-eight years service to Doctors, Clinics and Hospitals insures a kindly and understanding service to your debtors . . . Since **all money is paid to you**, you are still guardian of your accounts and all monies . . . You pay us commission only on such amounts as are paid to you . . . Won't you please write for a list of our Doctor and Clinic clients in Arkansas, and enlist our help, while the time for collections is opportune?

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COMMERCE BUILDING KANSAS CITY, 6, MISSOURI

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for administration in the patient's home, it will be available in combination packages providing two rubber-stoppered, serum-type vials, one containing 100,000 Oxford Units of Penicillin-C.S.C., the other permitting the withdrawal of 20 cubic centimeters of sterile pyrogen-free physiologic salt solution in which the penicillin is to be dissolved.

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The JOURNAL

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Vol. XLI

LITTLE ROCK, ARKANSAS, JANUARY, 1945

No. 8

TETANUS

W. J. SHEDDAN, M. D.
Osceola

"Another received an insignificant wound to speak of (for it was not deep) a little below his neck behind from a sharp dart; which being taken out not long after, he was drawn and distorted backwards, as in the opisthotonus. His jaws were also fastened; and, if anything moist was put into his mouth, and he attempted to swallow it, it returned again through the nose. In other respects he grew worse immediately. The second day he dy'd."—Hippocrates upon Epidemics. (Translated by Clifton, London, 1734.)

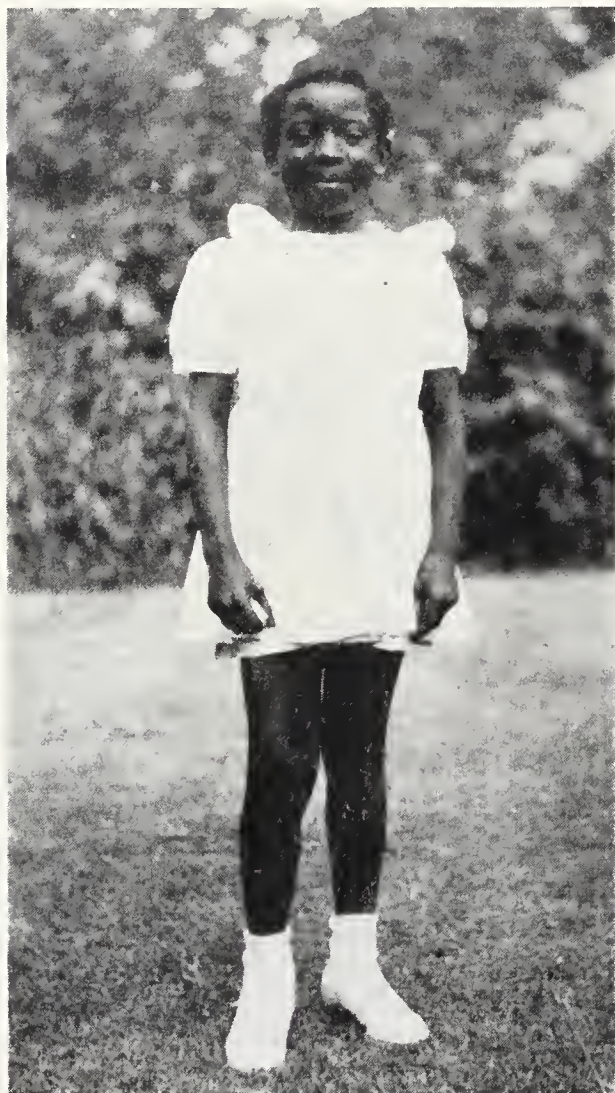
Tetanus, as you know, is an acute infectious disease caused by the infection of a wound with the spores of *Bacilli Tetani* but a few facts about this disease at this time might not be amiss. It is perhaps not a matter of common knowledge that the organism is harbored to a very consid-

erable extent in the human intestinal tract. Bauer and Meyer found spores of definitely toxic strains in 24.6 per cent of 487 specimens of feces from residents of California. Hence numerous cases of tetanus following peritoneal operations are on record. Then, too, in the past we have had cases of tetanus neonatorum which is now becoming very rare due to the proper routine care of the umbilical cord. The cases, however, with which we have our greatest trouble are those from a wound that is accidental. From the date of the wound we have an incubation period carrying from 3 days to several weeks, but most cases develop within from 10 to 14 days after the wound is suffered. With reference to the incubation period, it might we well to remind you that the shorter the incubation period the higher the mortality and, on the contrary, if your patients survive the eighth day, the better their chances of recovery. A certain number of cases of tetanus will get well anyway with ordinary



Before Treatment

symptomatic treatment and without antitoxin and, to the contrary, a certain number will, in spite of the best treatment which our present knowledge enables us to give, die. However, between these two groups lies the middle class of those who will die or get well according to their treatment, and by that treatment I mean the proper care of the wound, the intelligent use of



After Treatment

sedatives, and the prompt, well-directed, repeated use of large doses of antitoxin. At this time I wish to give you a case report of a child with tetanus who we will say comes under this middle class.

On May 15, 1943, I was called to see E. M., age 9, a well-developed and well-nourished Negro female. She gave a history of having cut the heel of her right foot on a piece of glass. Her home is on the south side of a bayou which runs through a barn lot a short distance to the east. Each day she waded up and down this bayou. On the 7th day after receiving the acci-

dental wound she became ill and at the first time I saw her she was having severe convulsions from which she did not relax completely at any time. She cried with severe abdominal pain and there was a definite board-like rigidity of the abdomen. The severe muscular contractions of her entire body caused severe pain. Opisthotonos was marked and she had the characteristic lockjaw or trismus. She had a mild temperature and rapid pulse and the usual sardonic facial expression. She also had great difficulty in swallowing. Having this picture before me I immediately started the following treatment.

The first 3 days she was given 320,000 international units of tetanus antitoxin daily (960,000). On the fourth and fifth days, 240,000 international units were given (480,000). On the sixth, seventh, eighth and ninth days, 160,000 units were given (640,000) and 80,000 units were administered on the tenth day at which time the antitoxin was discontinued. The total number of tetanus antitoxin given in the 10 days, 2,160,000 international units or 1,080,000 American units.

The next important step in the treatment of tetanus is the judicious employment of all available sedative measures. In this case I gave 4 grains of sodium luminal hypodermically with morphine sulphate $\frac{1}{4}$ grain every four hours. This gave excellent results until the tenth day at which time the patient became extremely restless, crying with severe abdominal pain, and the muscular rigidity became severe. At this time I called in a consultant, and after consultation, we agreed that the patient having had 2,160,000 international units of tetanus antitoxin, sedation was most important at this time and at his suggestion we gave the patient $\frac{1}{6}$ grain morphine sulphate and 2 c.c. of 50 per cent magnesium sulphate hypodermically every four hours for 48 hours at which time all medication was discontinued. This drug was administered subcutaneously and intramuscularly by hypodermic. I believe it was Blake who used magnesium sulphate in the first case of human tetanus in 1906. I can assure you that no physician who has once seen the remarkable relaxing power of this salt upon an agonized tetanus patient can seriously doubt its value even though it be not in itself curative. This drug can be administered by four methods:

1. Subcutaneous. One and $\frac{2}{10}$ to 2 c.c. of a 25 per cent solution for each 20 pounds of body weight, four times in 24 hours. Continue until disappearance of symptoms. Less dangerous than other methods.

2. Intramuscular. Should be used only in severe spasms, as the drug is more dangerous by this method. Effect of drug in less than half an hour and lasts 2 or 3 hours.

3. Intravenous. Most dangerous method of all. Effect most prompt but may disappear in 30 minutes. Dose 6 per cent solution at rate of 2 c.c. per minute until relaxation.

4. Intraspinal. By this method you get effect of this drug in less than half an hour and relief lasts from 12 to 30 hours. Dose: Inject 1 c.c. of a 25 per cent solution for each 20 pounds, second dose 0.8 c.c. for each 20 pounds and only .5 c.c. per 20 pounds in a child. In the event you have excessive depression of respiration from magnesium sulphate inject 2.5 c.c. of calcium chloride in physiologic saline intravenously (slowly). The antidotal effect is seen almost immediately.

As to the method of giving tetanus antitoxin you may employ either of the four methods used for sedative drugs. Personally I use only the first three, namely, intravenous, intramuscular, and subcutaneous. I believe you get quicker action intravenously and more lasting effect by subcutaneous and intramuscular method. During the 28 years I have practiced medicine I have never yet seen a patient with tetanus who was given the antitoxin by the intraspinal method survive. For that reason and due to the fact that a patient with a severe opisthotonos, having a spinal column curved like a rainbow and exactly in a reverse position conducive to the proper administration by intraspinal route, I never use this method.

COMMUNIQUE

December 1, 1944.

To the Editor:

Your last letter, October, finally caught up with me. Have intended to drop you a line before but never could get around to it. I am serving with colored troops and that is really a job. Have very nice medical setup and like present station very much. Ran into several Arkansas boys on ship over but have lost contact with them now. The island is beautiful, weather ideal and plenty to do if we could find the time to do it. Enjoy receiving letters and Journal very much and hope they will start coming through again. Regards to everyone.

Yours,

A. C. Parker, 1st Lt., M.C.

MODERN CONCEPTS OF CARDIOVASCULAR DISEASE

COMMITTEE ON THE HEART ARKANSAS MEDICAL SOCIETY

C. T. CHAMBERLAIN, M. D., Chairman,
Fort Smith

While subacute bacterial endocarditis is not a common entity, the fact that the mortality in this disease has been, to all intents and purposes, practically 100%, should stimulate keen interest in the possibilities regarding the use of penicillin in its management. The committee, therefore, has selected for this month's presentation a summary of the present status of "The Use of Penicillin in the Treatment of Subacute Bacterial Endocarditis" by Charles A. Poindexter:

"A new attack on subacute bacterial endocarditis was made possible by three new developments: (1) Fleming's discovery of penicillin, (2) the subsequent purification and standardization by Florey and his co-workers, and (3) the American development of large scale production of the active purified form of the substance.

"Subacute Bacterial Endocarditis was, to say the least, a very discouraging disease. Although from time to time there appeared in the medical literature, reports of certain agents which seemed to have some effect on the bacteria, usually there were missing links that made the canny and experienced clinician doubtful as to the validity of diagnosis. Also there was thought to be a certain percentage of so-called spontaneous cures but again opinion was not unanimous. Certainly, considering the number of cases and the years of continued study, there were few survivals.

"Until 1943, on the cardiac and medical service of the hospital where the author works, we had not observed a single bona fide case of survival where the diagnosis was certain and where the infecting agent was *Streptococcus salivarius*. Sulfonamides appeared to have a temporary effect on the febrile reaction but in analyzing the response to growth of bacteria in the blood cultures, with neutralization by paraaminobenzoic acid, the bacteria were found to be present in about the usual numbers and there was not much in the way of demonstrable alteration in the clinical course of the disease. Likewise with specific strains of bacteriophage, neoarsphenamine, bismuth and other substances which undoubtedly inhibited the in vitro growth of the bacteria. Even in heavy and toxic doses the

course of the disease seemed to progress in about the usual manner.

"In penicillin we had available what appeared to be an ideal substance for the treatment of this particular disease. It was highly bactericidal for certain strains of the streptococcus viridans and paradoxically almost nontoxic for the host. In the early stages of the investigative work the results were not promising for such a potentially useful drug. The first case reported by Florey seemed encouraging in that there was marked clinical improvement during the time of administration but the end result was the same as usual. The report of Keffer, et al., was extremely discouraging, so that with the early scarcity of the drug it was thought not worthwhile to use it and the committee for distribution, on the basis of this report, were opposed to the use of the substance in cases of subacute bacterial endocarditis. However, Dawson had found that there was a definite clinical improvement in several of his cases and in one there appeared to be definite arrest. About the same time other isolated investigators tried the substance, when it was available, more or less out of desperation and found, much to their astonishment, that a certain percentage of cases responded and one obtained what was at least an arrest of the disease. Loewe and co-workers reported the results of treatment of cases with penicillin and heparin combined, in which there were seven consecutive successfully treated patients. Likewise MacNeal, et al., reported the apparent complete success in one case and several others where treatment was progressing very satisfactorily. To date, of the latter group, success has continued in a number of cases although as one might naturally expect, there have been failures. Since then, many patients have been treated and there are certainly a number of cases that apparently have been arrested. One uses this term arrest because it is only after a considerable period of time has elapsed, during which the patient has had a sterile blood culture and all signs of activity have disappeared, that one has any right to say cure.

"The successful treatment of subacute bacterial endocarditis requires some fundamental knowledge of the pathogenesis. It is not within the scope of this summary to present a review of the data that has been published on the disease, but it is a pathological process which develops in most instances on a precedingly injured portion of the endocardium whether that injury has come as a result of previous rheumatic or arteriosclerotic damage, congenital deformities or other trauma. The healing process by the nature of the

involvement must of necessity be slow, the longer the disease has been in progress the longer the process of healing. The healing of the infected thrombotic deposits are favored by certain mechanisms. These are (1) bacteriolysis, (2) phagocytosis, and (3) encapsulation and scar formation. These principles are particularly emphasized by MacNeal based on the experimental production of the disease. Apparently one deals with innumerable small culture tubes of bacteria covered by varying thicknesses of fibrin and scar tissue, some of them eliminated by phagocytosis and some of them burst emptying into the blood stream where they are apparently again deposited in another crypt and form another focus. Recognizing these facts it is obvious that the restraint of rapid multiplication of bacteria is essential to the success of the healing process, hence the therapeutic need of (1) physiological rest, (2) anti-infectious agents such as penicillin in the circulating blood, and (3) adequate nutrition for the defending cells. One must remember that there are several strains of streptococcus viridans. The three most common ones are (1) Salivarius, (2) Enterococcal, and (3) Bovine; in addition there are a number of other intermediate strains that are difficult to identify. Fortunately, the strain which is usually most susceptible to penicillin and also the most common one found in subacute bacterial endocarditis, is that of the salivarius group. Rarely are the other strains susceptible to the drug.

"In the routine treatment of the patient with the disease there are still many conflicting opinions. One certainly concerns the combined use of heparin with penicillin. There are certain theoretical pros and cons. The ingenuous method of administration devised by Lowe and his excellent reported results point to its use. However, the only other comparable series, namely that of MacNeal, seems to show equally good results without its use. Only continued study will tell whether or not the heparin is beneficial or essential. Apparently, best results are obtained by the following procedures. Blood cultures are taken on three successive days. The bacteria isolated from the culture are tested for strain and for penicillin susceptibility in varying dilutions. Almost always the susceptibility in vitro will indicate the potential usefulness of the drug. However, this is not always true as one notable case in our series has shown, so that probably the therapeutic effect of the drug should be tried, at least a short while, on the patient even if the particular strain seems to be insensitive to penicillin. Where the patient appears to be desper-

ately ill then penicillin should be started immediately and the bacterial testing done simultaneously.

"At the present time it is thought best to give large doses of penicillin, preferably ten to twenty thousand units every two hours. There are again conflicting opinions as to the best means of administration namely, intravenous, repeated or constant, intramuscular or subcutaneous. All methods have disadvantages but from experience gained it seems best to combine the repeated intravenous and intramuscular injections for it is necessary in some cases to continue the administration over a period of many months. Often one gives repeated injections intravenously during the day and intramuscular injections (usually in the buttock) at night. One must, however, maintain the injections at the regular intervals so that at all times the blood level of the drug is high and the bactericidal effect is always present. In addition to the use of penicillin one is justified in using any other substances which one has a reasonable right to believe have a deleterious effect on the growth of the bacteria or a beneficial influence on the building up of either the specific or general resistance of the individual suffering from the disease. Particularly helpful has been the repeated use, daily or every few days, of perfectly matched whole blood in small quantities so that the blood count is kept at or near a normal level as possible. This certainly should be continued during the entire course of the treatment. Blood cultures should be repeated at regular intervals always done with the addition of clarse, because without the latter one may have what appears to be a negative culture when in reality all one has is the local bacteriudal effect of the penicillin in the culture media. Treatment with penicillin should not be stopped until the blood culture has been persistently negative, until all signs of activity such as fever, tachycardia, rapidly changing heart sounds have disappeared and preferably until the sedimentation rate has returned to normal.

"In some cases, response to treatment is dramatic, in others slow and only after months does one seem to gain control over the infection. In others there are temporary responses only to be followed by a seeming resistance of the bacteria for the drug and the outcome is a failure with death due either to embolic phenomena or cardiac failure. In general, the greater the length of time that the patient has had the disease the greater length of time before arrest is established. One case in our series, as yet unpublished,

was treated for over nine months before the blood cultures remained persistently negative so that as long as there is any hope one should continue with treatment. The procedure is not as easy as it appears to be either for the physician or the patient. Although when the arrest occurs in a short period of time such as in two weeks as it has in some cases, there is little difficulty. Months of injections at two hour intervals is a stupendous task for both the physician and the patient. Also these cases require a tremendous economic backlog. Because of the nature of the disease it seems hardly possible that any treatment will offer a very high percentage of cures. Penicillin does offer an opportunity for arrest in certain cases and is a marked advance over any drug hitherto used. Perhaps time, a refinement of technique and the discovery of more potent penicillin-like substances will offer brighter chances for a higher percentage of cures."

Acknowledgment is hereby made of permission by the American Heart Association to publish the above.

NINETEENTH ANNUAL SESSION OF NATIONAL CONFERENCE ON MEDICAL SERVICE SET FOR CHICAGO, FEBRUARY 11, 1945

Postwar distribution of medical care will be the theme for the nineteenth annual session of the National Conference on Medical Service to be held in the Red Lacquer Room of the Palmer House in Chicago, Sunday, February 11, 1945.

Medical legislation, physical fitness program, rehabilitation of veterans, latest word from the Washington front, relationship between labor and farm groups and medicine are among the topics to be discussed by nationally known speakers who will appear on the program. Also listed on the program will be an open discussion on prepayment medical plans, the principal advantages and defects of both service and indemnity types of insurance being presented. Congressman Arthur L. Miller of Nebraska, author of the Miller Bill to unify certain health services, is to be among the speakers.

All members of the American Medical Association are invited to attend.

Detailed programs of the conference will be ready January 1 and may be obtained through any member of the executive committee or by writing Cleon A. Nafe, M. D., secretary, National Conference on Medical Service, 822 Hume Mansur Building, Indianapolis 4, Indiana.

COUNCIL ON MEDICAL SERVICE AND PUBLIC RELATIONS AMERI- CAN MEDICAL ASSOCIATION

The Council on Medical Service and Public Relations of the American Medical Association is holding a three day meeting at the Mayflower Hotel in Washington, D. C., on December 4, 5 and 6.

For the past year and a half the Council has been studying various suggested modifications of the distribution of medical care. This study has covered voluntary non-profit, industrial, commercial and hospitalization plans for reducing the costs of medical care. It has held conferences with various groups and agencies concerned with, or interested in, the distribution of medical care. Further conferences are being held at this meeting with members of Congress, representatives of the National Planning Association and with representatives of Labor.

The Council last June recommended to the House of Delegates of the American Medical Association, a revised platform, which was adopted by the house.

This platform is the basis of a more widespread distribution of medical care in a manner that will solve the financial problems of illness which confront many people.

Economically, there are four groups of people in the United States, (1) those who are financially well enough off to meet any situations which they may face; (2) those who can meet the ordinary costs of living and ordinary medical expenses, but who find it difficult to meet the costs of long and expensive illnesses; (3) those who can meet the costs of the bare necessities of life, but who cannot meet the costs of any sickness; and (4) the class which is dependent upon public aid for housing, clothing and nutrition, as well as medical care.

The first group is now satisfactorily cared for and no change in the distribution of their medical care is needed. The fourth group is also well-cared for in most areas. Those areas not providing such care should do so as outlined later. Groups two and three need help, and means for meeting that need are herein outlined.

Before outlining the methods advisable, however, it will be well to point out that the high costs of medical care are in hospitalization,

nursing care and in diagnosis. The actual cost of the physician's services is not the important factor in most cases.

It must also be borne in mind that there are areas in the United States where diagnostic facilities are inadequate and where preventive medical facilities are inadequate or lacking.

Remembering that the platform of the American Medical Association is "availability of medical care of a high quality to every person in the United States," how best can this platform be made a reality and the shortcomings of medical care remedied?

The medical profession has accepted the principle of insurance as one which will be of great assistance, but it continues to feel that this insurance must be on a voluntary basis in order to avoid political interference and to prevent the rendering of a mere quantity of medical care rather than quantity with high quality. It is not enough that medical care be available. It must be medical care of a high quality.

In the development of any new type of insurance it takes time to make it successful and acceptable. Various voluntary non-profit medical indemnity and service plans have been developed and modified and are being increasingly well distributed over the country. Growth has been slow, but during the past year growth has been more rapid, and ideas as to the best type of plan are gradually crystallizing. There have been industrial plans existing in some cases for as long as 20 years, but there are many which have developed during the past few years. Commercial insurance is becoming increasingly available. Group hospital insurance has grown rapidly. There are now over 16,000,000 people covered by group hospital insurance; there are about 25,000,000 covered, to at least some degree, by voluntary non-profit medical, industrial and commercial plans. These plans must be made available to everyone desiring coverage at a cost within his means to pay.

The Council on Medical Service and Public Relations has been authorized to appoint a Director of Insurance to correlate and coordinate existing plans and assist in developing new ones so that the whole country may be covered by available insurance plans. The Council feels that such plans, including group hospital insurance, can be made effective at a far less cost and with more satisfactory service than any compulsory government controlled plans.

State, counties and towns are urged to consider the purchase of these voluntary insurance policies for the indigent and the near indigent.

The American Medical Association also in its platform has stated that there are too many counties or districts without adequate health supervision and has urged that every area be properly covered. Extension of medical care for the indigent and medically indigent in those areas not now giving proper care is necessary. Federal funds may be used for extending public health facilities and medical care of the indigent if the local community is unable to do so, but the administration of the problem should be decentralized and local rather than federal.

There is now available information on the needs of communities as to hospitals, diagnostic facilities and practicing physicians. The Council proposes to enlist the aid of state medical societies in relieving any shortages in the various communities, and to make certain that present facilities are used to the utmost.

Finally. For 70 years the American Medical Association has stood for a Federal Department of Health, under which shall be gathered all federal departments and bureaus dealing with the various problems of health except the Army and Navy, with a Secretary in the cabinet as the head of the department, such Secretary to be a qualified physician.

To summarize, therefore, our plan is:

1. Continued expansion of the practice of medicine with full development of approved voluntary hospital, medical, indemnity, industrial and commercial insurance against the costs of medical care.

2. Development of public health facilities for preventive medicine all over the country.

3. Development of adequate diagnostic facilities everywhere.

4. The use of the voluntary insurance principle in caring for the indigent and medically indigent.

5. The development of hospital facilities where present facilities are used to the utmost and are still inadequate.

6. The use of federal funds to aid communities in public health measures, care of the indigent and construction of necessary hospitals, when local communities are unable to finance the projects, but with retention of local administration.

7. The creation of a unified Federal Department of Health, as above outlined.

The Council is familiar with the various surveys which have been made and it also realizes that other surveys will shortly be coming out, some of them made purely to blind the eyes of the public

and to be used as propaganda for government controlled medicine.

The Council believes that the facts are that the public is demanding a method of prepaying its medical bills, particularly in the case of so-called catastrophic illness, and that it wants that method on a voluntary basis. It further desires that medical care to be of a high quality and readily available.

The American Medical Association, which represents the **practicing** physicians of the United States, will do its best to see that the public gets it.

"YOUR DOCTOR SPEAKS"

War-busy physicians who would like to interpret many medical developments to their patients but are prevented by the sheer lack of available time, will be interested in the broad new educational campaign created by The Upjohn Company.

The campaign takes recent medical developments, often of life-saving value to the American public, and presents the facts simply and attractively. The effort is made to give information of immediate practical help, based on sound medical principles, and carrying a hopeful note.

Each message has been carefully checked by leading authorities of the particular field, not only for accuracy but also for the wisdom of the presentation of the facts to the consumer. Assistance in framing the messages and enthusiastic approval of the campaign have been expressed by medical leaders.

Throughout 1945, messages will appear on pneumonia, pregnancy, cancer, whooping cough, stomach ulcers, the menopause and other vital health subjects of immediate interest. They will say in simple language what the physician might tell his patients if he had the leisure to do so.

In each message, the physician is presented as authoritative, yet still a warm human being. He frankly asks for cooperation from his patients so that together they can vanquish disease. Many readers who may be remote from their accustomed family physician, will no longer feel so isolated when they recognize that all doctors are grouped together to bring the benefits of modern medical discoveries to all.

FOR SALE—Tycos No. 5090 aneroid sphygmomanometer with bandage type sleeve, leather case, splendid condition. \$22.50. Mrs. J. C. Poindexter, 3216 Southern Avenue, Shreveport 49, Louisiana.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

UNSUSPECTING carriers and spreaders of the tubercle bacillus comprise a numerically small but important minority of the population. Though most general hospitals dislike to receive known cases of pulmonary tuberculosis for treatment of unrelated conditions, their patients and personnel nevertheless remain under constant threat of tuberculous infection. This condition obtains because simple, adequate measures are not taken by the institution to detect among the employees, staff and persons admitted as patients the presence of unrecognized and unreported tuberculosis.

TUBERCULOSIS CONTROL IN HOSPITALS

Few hospitals will accept tuberculosis of the lung as a disease to be treated within their walls except the large public institutions with special facilities for that purpose. Recently private hospitals in Chicago were asked:

1. Do you admit patients with pulmonary tuberculosis to your hospital for treatment of that disease?
2. Do you admit patients with known pulmonary tuberculosis to your hospital for treatment of other conditions?

Of the 73 hospitals which replied, 5 answered question one with "Yes"; 68 with "No"; 25 replied to question two with "Yes" and 48 with "No" or with comments which amounted to a negative reply. The answers indicated that hospital administrators do not consider the admission of the tuberculous an asset to hospital service. In fact many of them thought this was an attempt to uncover an administrative deficiency.

In a community with sufficient beds available in tuberculosis hospitals this attitude does not hamper phthisiotherapy, although in the past physicians have been deprived of facilities to hospitalize their patients in this manner. With the increase of surgical treatment this has often proved hampering. In communities with inadequate facilities for the treatment of tuberculosis failure to exploit all the available space, especially when numbers of general hospital beds were vacant, has seemed unjustified.

Fear of Infection

The reason for this is the fear of infecting non-tuberculous patients and hospital personnel housed under the same roof. This precaution

might be justified if the refusal could really lead to a hospital atmosphere free of tubercle bacilli, but that is not the case.

In recent years, since we have become aware of obscure tuberculosis, our distrust of a negative history and physical examination has become deep-seated and justified. Again and again evidence has shown that any hospital may have patients with unknown and open pulmonary tuberculosis in its rooms and wards however little the ailment for which these persons were admitted may have to do with pulmonary disease.

Routine Chest X-rays

Only universal X-ray examinations of the chest of all patients, regardless of the nature of their complaint, could lead to exclusion of the tuberculous. The University of Chicago Clinics and the affiliated Provident Hospital have X-rayed all clinic admissions for some years with most beneficial results. As a method of avoiding contamination, however, this is only part of the necessary effort. As a means of keeping tuberculosis out of hospitals, pre-admission X-rays would lead to an unnecessary increase in the rejection of patients badly in need of care.

Many patients will always enter hospitals without a previous examination, and they cannot be asked to leave if tuberculosis is discovered. Even if a discharge could be effected without harm to the patients, where should they go for treatment? Tuberculosis hospitals could hardly be expected to engage in the treatment of all extra-pulmonary, non-tuberculous conditions. Sanatoria are usually not located or staffed for the purposes of general medicine and surgery. Many

communities have no facilities specifically intended for the treatment of patients with tuberculosis.

Danger of Unrecognized TB

General hospitals should accept the necessity of housing tuberculous patients. The danger of infection arises from not recognizing their pulmonary infection, as has been the unavoidable fact up to now.

Proper isolation in one wing, floor, or section of the building is easily accomplished. At the University of Chicago Clinics this has been done during the past twelve years. Through knowing who and where our tuberculous patients are we are avoiding the most acute danger of contamination which always arises where germs are being spread without the knowledge of either the distributor or the recipient.

Staff Examination

Isolation protects the medical and nursing staff and other employees against infection from the patient. However, to make tuberculosis control in a hospital complete, physicians, nurses, attendants, etc., have to be protected not only from patients but from each other and patients have to be guarded against infection from members of the personnel.

Nearly 15 years ago when the University Clinics introduced X-ray examination of the chest by roentgenograms for all nurses, the supervisor of the operating rooms and the nurse in charge of the sterilizing room for the newborn were found with active tuberculosis. Neither was aware of her condition. Stereoscopic roentgenograms were then made obligatory for all physicians and nurses on taking employment, with re-examinations every year for those on general duty and every three months for the personnel of the tuberculosis division.

General Hospital Personnel

Other personnel were exempt from this routine. About a year later, positive sputum findings began to be reported in patients where no other findings suggested tuberculous infection. The clinical findings in most of these patients suggested upper respiratory or bronchitic involvement. The suggestion that an X-ray examination of the chest of the members of the laboratory staff be made was resented by that staff and rejected by administrative officers.

Eventually, it was found that the laboratory worker in charge of sputum tests, a plump and healthy appearing girl, had extensive cavernous tuberculosis with an almost pure culture of acid fast bacilli in her sputum. She had contaminated

the patients' specimens. The embarrassment of apologizing to the patients in question and of revoking the reports to the health department had a most beneficial effect. Roentgen examination of the chest has since been obligatory for all staff members and hospital employees and has been gratefully received by almost all of them.

Sincere Effort Needed

Experiences like this may seem extraordinary. The author believes they appear so only because there has been no great drive to uncover tuberculosis in hospital personnel. There can be no cause for the hesitation on the part of the general hospital to put its house in order with regard to tuberculosis other than inertia and the fear of administrative commotion.

A painstaking design and observance of rules governing the diagnosis and isolation of the disease in patients and employees will make it possible with safety to admit tuberculous patients to general hospitals. There is no reason why all this cannot be accomplished by voluntary efforts. It is obvious from our newer experience with tuberculosis that such hospitalization is one of the great necessities to achieve the basic aim of all medical endeavor—the saving of human life.

Tuberculosis Control in Hospitals, Robert G. Bloch, M. D., The NTA Bulletin, August, 1944.

COMMUNIQUE

November 10, 1944.

To the Editor:

The September issue of Random Thots mentioned that it had been some time since you have heard from me, so here goes.

Today I complete thirty months of overseas service. Isn't that some kind of record for the Arkansas Medical Society members? About three months ago I was told that I was to go home but I'm still here and will only believe it when I am on the way.

This promises to be the roughest winter yet. Last night we had our first snow and it is plenty cold today.

The Tedeschi, have been throwing a lot of shells our way lately and it takes me back to the days of Anzio and Cassino. The shell with my name on it hasn't come in yet but there have been times when I wasn't so sure.

Please extend a Merry Christmas and Happy New Year to all the members of the Arkansas Medical Society for me.

Sincerely,
John M. Samuel, Major, M. C.

THE JOURNAL

OF THE

ARKANSAS MEDICAL SOCIETY

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under direction of the Council

W. R. BROOKSHER, M. D., Editor
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EDITORIAL

COUNCIL ON MEDICAL SERVICE AND PUBLIC RELATIONS AMERICAN MEDICAL ASSOCIATION

A statement prepared by Dr. John H. Fitzgibbon, Chairman, approved and released by the Council December 6, 1944.

The objective of the medical profession of this country is the provision of good medical care to every person in the United States. The Council on Medical Service and Public Relations intends to promote this objective. Solution of the problem of providing medical care of good quality is not simple because of varying conditions in different communities, particularly economic and environmental conditions which, while not generally considered health problems, have a marked effect upon the health of persons concerned. Eradication of conditions contributing to poor health in a community requires joint action by the medical profession and other public spirited persons.

In providing good medical care to the entire nation three phases of the problem must be solved.

(1) Adequate trained professional personnel

and facilities for providing preventive, diagnostic and treatment services must be made available to all areas;

(2) Sound economic arrangements for financing these services and facilities must be set up, and

(3) Educational efforts will be required to inform the people of the value of good medical care in order to induce them to make intelligent use of the services and facilities made available.

Members of our Council believe that the platform of the American Medical Association contains the fundamental principles upon which a sound, progressive plan for providing good medical care to the nation may be established. Accomplishment of this objective will require the sincere cooperation of the medical and allied professions, government, industry, labor, and many other interested groups and individuals.

Solution of this problem does not and will not require compulsion. The medical profession is now and has been agreed for years upon definite principles of a constructive nature, which is accepted by others concerned in this matter, will lead to a satisfactory solution of the problem upon a voluntary basis. Unfortunately these principles embodied in the platform of the American Medical Association are apparently not known to a great many people outside the medical profession. It is one of the functions of the Council on Medical Service and Public Relations to make these principles and their implications known to the medical profession, interested citizens, and public servants.

As all physicians know, the medical profession has advocated for nearly seventy years the establishment of a federal department of health under which all medical and health functions of the national government, exclusive of those of the army and navy, may be coordinated and administered. Surely it is time to simplify and coordinate all these activities under one head and a commission of competent and well qualified medical men. The medical profession seeks and will welcome an opportunity to cooperate and coordinate its efforts with such an agency, so that the present chaos may be abolished and constructive, cooperative and coordinated efforts of all concerned may be directed to a proper solution of the problems of medical care.

Reasonable agreement can surely be reached upon other planks of the American Medical Association.

"A. In the extension of medical services to all people, the utmost utilization of qualified

medical and hospital facilities already established.

"B. The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability, including the development and extension of voluntary hospital insurance and voluntary medical insurance.

"C. Expansion of public health and medical services consistent with the American system of democracy.

"D. The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health and the care of the sick on proof of such need.

"E. The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.

"F. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.

"G. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration."

Certainly voluntary methods of insurance, utilization of existing facilities as far as possible, preservation of private practice, expansion of public health services, aid to the indigent or impoverished communities, and the principle of local determination of need and local control of administration are basic principals of Americanism. These things American physicians are agreed upon. Is it not poor judgment to ignore or attempt to circumvent this well-considered and thoroughly studied set of principles which are the expression of a public-spirited profession devoted to human welfare?

Understanding of these principles by the public and our lawmakers will pave the way for enthusiastic cooperation of the medical profession and other responsible groups in solving the problem of provision of good medical care to all.

THE NAVY NEEDS DOCTORS

The serious need for physicians in the U. S. Naval Reserve is emphasized in recent communications from the Bureau of Naval Personnel of the Navy Department.

Since the Army discontinued the commissioning of physicians, it was anticipated that the procurement of physicians by the Navy would

be increased. Actually the number of physicians commissioned in the U. S. Naval Reserve has been decreasing. Three thousand physicians are needed as soon as possible to ease the emergency which now exists. Even this number will not actually satisfy the demand.

Your state (county) has already contributed more than its share of physicians to the various services, but it is necessary to secure every physician who is not absolutely essential to the health and welfare of your state (county).

Many physical defects may be waived for commission in the U. S. Naval Medical Corps Reserve. This is being done in order to help fill the urgent need for medical officers. The age limit is now 55. Doctors up to the age of 60 may apply for commission and be assigned to the U. S. Veterans Administration. Rank is based on both age and experience.

Any applicant should consult the State Chairman of Procurement and Assignment Service for Physicians regarding his possible release, and then contact the Director of Naval Officer Procurement, 611 Gravier St., New Orleans, Louisiana.

REGIONAL CONFERENCE ON MEDICAL SERVICE AND PUBLIC RELATIONS

Representatives from the states of Arkansas, Kansas, Missouri, Oklahoma and Texas met in Kansas City, December 17th, in the first regional conference held by the Council on Medical Service and Public Relations of the American Medical Association. The meeting was arranged by Dr. James R. McVay, member of the Council, and Dr. Joseph Lawrence, director of the Washington office of the American Medical Association, Mr. W. J. Holloway, Jr., director of the Bureau of Legal Medicine and Legislation, Dr. C. M. Peterson and others of the headquarters office of the American Medical Association were in attendance. Approximately thirty state representatives were present. The organization and progress of the Council, the program of the Washington office, post-war medical education, location of returning medical officers, rehabilitation and prepaid medical care plans were informally and extensively discussed. This conference was a most profitable meeting and is a good step forward in the relations of state medical societies and the American Medical Association. It is hoped that these conferences may be continued and that, in due course, they may be held within the respective states in order that even more members may attend and learn of the varied activities of the national organization.

EDITORIAL COMMENT

TO COUNTY SOCIETY SECRETARIES AND MEMBERS OF THE ARKANSAS MEDICAL SOCIETY

Those of you who wish to present papers on the 1945 scientific session of the Society in Little Rock are asked to notify your county society secretary, giving the title of your paper, or the chairman of the Committee on Scientific Work, Dr. M. C. Hawkins, Jr., Searcy. Notices must be received by the state committee not later than January 15th.

COMMUNIQUE

December 3, 1944.

To the Editor:

Thanks for sending me the Service Editions of "Random Thots." I have been receiving them regularly and enjoy every one of them. The idea of having different doctors write them every once in a while is a good one. It gives us a look-see of what is going on over the state. Of course, we in the service are glad to get the ones you write, too.

I am one whose address has not changed much since I have been here at Fort Sam Houston ever since I came into service except for a "strange interlude" of three months "foreign service" in Oklahoma.

However, I do have a new address, as below. SPRC is the Southern Personnel Reassignment Center. My duties consist of examining returnees (both officers and enlisted men) returning from all the battle fronts.

The one idea of all of us in the service is to get the job done as quickly as possible and get back home. Thanks again for the "Random Thots"—keep 'em coming.

Sincerely,

Wilfred R. Parsons, Capt., M.C.
SPRC Disp H 2,
Fort Sam Houston, Texas.

VITAMIN ADVERTISING AND THE MEAD JOHNSON POLICY

The present spectacle of vitamin advertising running riot in newspapers and magazines and via radio emphasizes the importance of the physician as a controlling agent in the use of vitamin products.

Mead Johnson & Company feel that vitamin therapy, like infant feeding, should be in the hands of the medical profession, and consequently refrain from exploiting vitamins to the public.

PROCEEDINGS OF SOCIETIES

Woodruff County Medical Society has elected the following officers: President, J. F. Hays, Augusta; vice-president, W. J. B. Williams, Cotton Plant; secretary-treasurer, C. E. Dungan, Augusta; delegate, F. C. Maguire, Augusta, and alternate, J. W. Morris, McCrory.

The Ouachita County Medical Society met in regular monthly session December 7, at the Camden hospital. The hospital served a delightful banquet for the members. Speakers were as follows: "Neurological Surgery," Robert Watson, Little Rock, and "Penicillin in Osteomyelitis," Joe Shuffield, Little Rock. The following new officers were elected: President, Sam Thompson; vice-president, Rowland Robins; secretary, R. B. Robins; delegate, J. B. Jameson; and alternate, B. V. Powell. —R. B. Robins, Secretary.

The Craighead-Poinsett County Medical Society met in dinner session at Jonesboro December 7th. Wallace D. English, Cardwell, Missouri, addressed the meeting on "Latest Treatment of Malaria" and Mrs. David Gates, of Forrest City, read several Negro poems. The following officers were elected: President, Jos. W. Ledbetter, Jonesboro; vice-president, E. J. Stroud, Jonesboro; secretary-treasurer, J. H. McCurry, Cash; censor, L. H. McDaniel, Tyronza; delegates, L. H. McDaniel and J. H. McCurry; alternates, J. K. Jones, Lepanto, and W. C. Overstreet, Jonesboro. —J. H. McCurry, Secretary.

Drew County Medical Society has elected the following officers: President, J. P. Price; Secretary-Treasurer, L. F. Billingsley, and Delegate, J. S. Wilson.

Benton County Medical Society elected the following officers at a dinner session in Bentonville, December 14th: President, W. A. Pickens, Bentonville; Vice-President, C. S. Wilson, Siloam Springs; Secretary-Treasurer, Geo. M. Love; Delegate, L. O. Greene, Pea Ridge; and Alternate, Geo. M. Love.

Geo. M. Love, Secretary.

Sevier County Medical Society has elected the following officers: President, R. C. Dickinson; Vice-President, C. A. Archer; Secretary-Treasurer, C. E. Kitchens; Delegate, R. C. Dickinson, and Alternate, C. E. Kitchens.

The Howard-Pike County Medical Society has elected the following officers: President, Edwin V. Dildy, Jr., Mineral Springs; Vice-President, J. G. Waldrop, Nashville; Secretary-Treasurer, M. D. Duncan, Murfreesboro; Delegate, J. G. Waldrop, and Alternate, E. V. Dildy, Nashville.

Garland County Medical Society has elected the following officers: President, O. A. Smith; Vice-President, L. E. Reed; Secretary-Treasurer, W. E. Gray; Delegates, J. M. Proctor, J. S. Stell and C. E. Garratt, and Alternates, G. C. Coffey, Foster Jarrell and D. C. Lee.

The Sebastian County Medical Society was addressed December 19th by I. M. Sternberg, D. D. S., on "The Century Celebration of the Discovery of Anesthesia." The following officers were elected: President, W. F. Adams; Vice-President, C. W. Hall; Secretary, D. W. Goldstein; Treasurer, W. R. Brooksher, and Member, Board of Censors, I. F. Jones.

D. W. Goldstein, Secretary.

The Saint Francis County Medical Society has elected the following officers: President, J. S. Davidson; Vice-President, J. M. Roy; Secretary-Treasurer, J. O. Rush; Delegate, J. M. Roy, and Alternate, J. O. Rush, all of Forrest City.

The Southeast Arkansas Medical Society met at McGehee November 20th for the following program: "Help from the X-ray," D. A. Rhinehart, and "Low Back Pain," W. V. Newman, both speakers of Little Rock.

COMMUNIQUE

November 6, 1944.

To the Editor:

Sorry I have been so long in writing but have been moving about so much haven't had time to keep up my correspondence. However, I have been getting The Journal right along even if it has been by circuitous routes.

Nothing of much interest to report with the exception that I have been out in the field most of the time since I last wrote you. I was in the Regional Hospital at Camp Robinson for a time but that was too good to last so I was transferred to Texas where I have been since.

Sincerely,

J. W. Kennedy, Lt., M.C.,
127th Evacuation Hospital,
Camp Bowie, Texas.

PERSONALS AND NEWS ITEMS

The following members were registered at the Saint Louis session of the Southern Medical Association: Hoyt R. Allen, Little Rock; C. A. Archer, Jr., Conway; E. Baker, Dermott; E. E. Barlow, Dermott; J. H. Benefield, Fort Smith; Byron Bennett, Little Rock; Earl J. Bieri, Hot Springs National Park; Jos. P. Bremer, Cedar Point; P. B. Carrigan, Hope; F. Walter Carruthers, Little Rock; Chas. T. Chamberlain, Fort Smith; O. H. Clopton, Rector; W. G. Cooper, Jr., Little Rock; Chas. W. Dixon, Gould; Paul C. Eschweiler, Little Rock; Alan A. Gilbert, Fayetteville; J. G. Gladden, Harrison; Wm. Paul Gray, Batesville; W. B. Grayson, Little Rock; P. L. Hathcock, Fayetteville; C. R. Henry, Little Rock; W. G. Hodges, Malvern; Earle H. Hunt, Clarksville; R. H. Huntington, Fayetteville; R. R. Kirkpatrick, Texarkana; J. C. Land, Walnut Ridge; Ruth Ellis Lesh, Fayetteville; W. T. Lowe, Pine Bluff; W. H. Martin, Holly Grove; Madeline M. Melson, Little Rock; O. C. Melson, Little Rock; Roy I. Millard, Russellville; H. E. Mobley, Morrilton; Vern E. Morgan, Little Rock; E. J. Munn, El Dorado; J. H. McCurry, Cash; J. P. Price, Jr., Monticello; Byron L. Robinson, Little Rock; Porter R. Rodgers, Searcy; Martin Russell, El Dorado; Euclid M. Smith, Hot Springs National Park; J. A. Summers, Little Rock; A. B. Tate, Russellville; J. Brooks Tate, Texarkana; W. H. Toland, Nashville; A. H. Tribble, Hot Springs National Park; H. King Wade, Hot Springs National Park; Charles Wallis, Little Rock; C. Fletcher Watson, Little Rock, and S. J. Wolferman, Fort Smith.

W. J. Ketz has been elected High Priest of the Batesville chapter, Royal Arch Masons.

Lt. A. C. Parker, Clarkedale, is now in service overseas.

BORN—On December 2, 1944, a son, Gean Brooks Atkinson, to Dr. and Mrs. Gean Atkinson, Blytheville.

Major J. M. Walls, Blytheville, has returned from overseas duty and is awaiting re-assignment at Hot Springs National Park.

Lt. Col. Charles H. Lutterloh, Hot Springs National Park, has been transferred to Station Hospital, Fort Sheridan, Illinois.

Lt. L. T. Taylor, Star City, is now in service overseas with a marine aviation group.

John W. Cole has been elected worshipful master of the Sheridan Masonic lodge.

Capt. Robert W. Boyle, Little Rock, is now stationed at Regional Hospital No. 3, Fort Bragg, North Carolina.

Capt. Huie H. Smith, Little Rock, is now assigned to a station hospital overseas.

Hugh Savage, Little Rock, now stationed at Headquarters, A. T. C., Washington, has been promoted to major.

Capt. Frank C. Maguire, Augusta, is now stationed with Medical Section, A. S. F. at Fort Lewis, Washington.

Capt. James D. Hayes, Little Rock, is now stationed overseas with a field hospital.

Miss Frances Atwater, formerly Advertising Manager of Lederle Laboratories, Inc., New York City, joined the sales promotion staff of Wyeth, Incorporated, Philadelphia, Pa., on November 1st as Executive Assistant to Mr. Stuart V. Smith, Director of Sales.

Capt. Doyle W. Fulmer, Little Rock, is now hospitalized at Northington General Hospital, Tuscaloosa, Alabama.

Maj. Monroe D. McClain, Little Rock, is now stationed with Headquarters, 86th Division Artillery, Camp San Luis Obispo, California.

Capt. Thos. L. Adair, Searcy, is now stationed at Camp Beale, California.

Maj. C. H. Reagan, Marked Tree, is now assigned to an evacuation hospital overseas.

Capt. Hollis H. Buckelew, Little Rock, recently addressed the Associated Industries of Massachusetts in Boston on the reconditioning of soldiers.

Capt. W. O. Loftis, Pocahontas, is now on duty at Brooke General Hospital, San Antonio, Texas.

"The Pathological Lesions in the Brain in Malaria" by R. H. Rigdon, Little Rock, appeared in the December issue of the Southern Medical Journal.

D. W. Goldstein, Fort Smith, spent a recent vacation in Mississippi and at New Orleans.

Charles P. Harris, Jonesboro, now on duty at Camp Stewart, Georgia, has been promoted to captain.

The Upjohn Company, Kalamazoo, Michigan, has received the Army-Navy Production Award for excellence in the manufacture of materials for our armed forces. The award was presented November 24th.

Lt. Comdr. George F. Stocker, Fort Smith, has been assigned to Naval Hospital, Bethesda, Maryland, for a course in roentgenology.

O. C. Melson, Little Rock, was installed as Councilor from Arkansas to the Southern Medical Association at the November meeting in Saint Louis.

The Past-President's Medal of the Southern Medical Association, posthumously awarded to W. T. Wootton, was presented to Lt. Col. Euclid M. Smith at the Saint Louis session.

Lt. James B. Holder, Monticello, is now stationed overseas with a general hospital.

Huie Haskell Smith, Little Rock, has been promoted to captain.

Comdr. R. J. Calcote, Little Rock, has returned from overseas duty and is now assigned at Naval Hospital, Fort Eustis, Virginia.

I. F. Jones, Fort Smith, has been elected to fellowship in the American College of Surgeons.

A. A. Blair, Fort Smith, took special work in New York City during November.

Capt. Art B. Martin, Fort Smith, is now stationed overseas.

RANDOM THOUGHTS OF THE SECRETARY

November 21st. Today reviewing "Fort Ord Panorama" which finds Charlie Finney, press-agented and photographed with his story of the Ledo road and we are glad to again see Finney even in Class "B" uniform photograph. Hearing today also that Fount Richardson, late of India, has finally rotated to turn up in Fayetteville.

November 24th. In Skelly Stadium whose sidelines have everything on them except an exhibition of post-war kitchen cabinets, we see an exceptional Tulsa University team humble the Razorbacks, and if any Georgia Tech readers see this, we urge they start preparations now for a better pass defense. Seated with the Razorbacks is colleague Alan Gilbert apparently philosophical about the whole thing, leaving to Fowler the professional decisions.

December 7th. Dining out this evening we observe Clarke with three women at another table, setting a pattern which no member of the Cooper Clinic can equal.

December 8th. Celebrating our natal day with the Eberles and the Wolfermans, affording the opportunity for reminiscent conversations, perhaps appropriate on this particular day.

December 13th. John Samuel reports in from Camp Chaffee after thirty months in Africa, Italy and way stations with the First Armored Division and although our welcome is restricted to telephone conversation, we know that leave at home over Christmas is going to be an occasion here.

December 17th. Today in regional conference at Kansas City where the plans of the Council on Medical Service and Public Relations are unveiled to those present and we are much impressed with the enthusiasm which greets pre-paid medical care. Peterson of the AMA staff puts in a good word for Cathey, already busy on the job as committee chairman on industrial health. Tonight homeward on the Kansas City Southern finding a wartime novelty, the Pullman porter who shines your shoes.

December 18th. We know it is a matter of no moment to anyone else but today comes a "thank you" letter from Surgeon-General Kirk for our work with the Procurement and Assignment job, thus identifying himself with the hopeless minority in comments received, but, by this single note of thanks, it is no longer a shut-out for us.

December 23rd. With the president commenting on columnists today, we wish it understood that we consider ourselves an "excrement" and not a "diarist" as he defines the terms.

December 25th. Though it may be obscured by clouds the Star which first shone over the hills of Judea shines on and some day there will truly be a world of "Peace on Earth and Good Will to Man."

COMMUNIQUE

October 18, 1944.

To the Editor:

This is the first opportunity that I have had to write anyone except an occasional short note

to my wife since arrival in Europe, somewhat over two months ago, but I have been anxious all along for you to know that I am receiving The Journal and "Random Thots," and enjoy both very much.

I have been quite content about not seeing any Arkansas doctors until learning of the Hempstead County Medical Society meeting in London and other meetings of old acquaintances. The London meeting being especially disappointing as I was only 30 miles from London at the time, 2 July. The only Arkansas doctor that I have contacted in the past six months was Charles C. Reed, Station Hospital, Camp Shanks. This was an accidental meeting and the sudden departure of my boat interfered with any future chats.

In regard to Major Robert G. Johnston's letter in the September, 1944, Journal, he stated that there was practically no sign of psychoneurosis among casualties admitted to his evacuation hospital. A different picture is found in a battalion aid station here. I am not at liberty to give information as to the number of casualties, however in my present position I have the opportunity to observe the patients of three or more battalion aid stations during each battle, and of the patients evacuated at least one-third are "combat exhaustion" cases. "Combat exhaustion" is an Army diagnosis that includes physical exhaustion as well as psychoneurosis. During the 3rd or 4th day of one particular engagement in which the enemy resistance was extremely great, the combat exhaustion cases made up 50 per cent of total casualties evacuated, with a very small number of physical exhaustion cases as most of these were returned to duty after 12 to 24 hours' rest at the aid station.

The number of malingerers is surprisingly low in the front line aid stations during actual fighting. These boys show up more frequently after the fighting quiets down, during moves and in rest areas.

We will all agree with "excellent esprit de corps among the wounded." A piece of shrapnel just large enough to initiate evacuation to a comfortable hospital, with nurses, has changed the expression of fear to that of a broad smile on the face of many soldiers. Personally, I have been in several spots that just that sort of injury would have been welcomed.

Glenn G. Hairston, Maj., M.C.

CLYDE LIPSEY McNEIL, age 52, died suddenly at his home in Rogers November 24th. Born in Rogers September 18, 1892, he attended the schools there and was a member of the first class to graduate from the Rogers High School. Graduating from Vanderbilt University School of Medicine in 1917, he served an internship at Vassar Hospital, Poughkeepsie, New York, and then entered the Army Medical Corps, serving during World War I and until in 1919. Subsequent to release from military service, he began the study of orthopedics but interrupted this course to return to Rogers because of his mother's



Clyde L. McNeil, M.D.

health and remained there in practice until his death. He was married to Miss Gladys McGee of Mountain Grove, Missouri, on December 8, 1930, who, with two brothers and a sister, survives him. Active in medical organization throughout his career, he had served in various offices of the Benton County Medical Society and became Councilor from the Tenth District in the Arkansas Medical Society at the 1937 annual session and had served continuously from that date. He was elected Chairman of the Council in 1942 and served for two years. He was a Fellow of the American Medical Association and

of the American College of Surgeons, a member of the Board of Directors of the Rogers Chamber of Commerce and of the First Federal Savings and Loan Association, a member of the American Legion, a charter member and past-president of the Rogers Kiwanis Club, a member and past worshipful master of the Rogers Masonic lodge and a member of the Knights Templar and the Shrine.

GEORGE LOUIS HENDERSON, age 73, died at his home in Conway November 23rd. A native of Faulkner county, he graduated from the University of Arkansas School of Medicine in 1907, first locating at Greenbrier. During World War I he served with the Army Medical Corps. He was a member of the Methodist church, of the Woodmen of the World and of the Masonic bodies. He was elected to honorary membership in the Faulkner County Medical Society and in the Arkansas Medical Society in 1939. Surviving relatives are his wife, a son and three daughters.

CHARLES STANHOPE MEANS, age 63, died at his home in Fort Smith November 21st after a prolonged illness. Born in Mississippi, he graduated from the University of Arkansas School of Medicine in 1909 and first practiced at Jenny Lind, Arkansas, moving to Fort Smith in 1924. Active in the Sebastian County Medical Society throughout the years of his practice, he served that organization as president and in other official capacities. He was a member of the Central Presbyterian Church, of the Masonic bodies and the Eastern Star. For many years he taught a Sunday School class named for him. Surviving him are his wife and a son.

NALL CARROLL McCOWN, age 60, Forrest City, died November 25th. Born in Calhoun, Kentucky, August 31, 1883, he graduated from Louisville and Hospital Medical College in 1908. In 1910 he married Miss Annette Stringfellow and located in Saint Francis county where he had practiced medicine continuously since. A veteran of the Spanish-American and World War I, he was a member of the American Legion, of the Masonic lodge and the Methodist church. He had served as city and county health officer and was a past-president of the Saint Francis County Medical Society. Surviving relatives are his wife, two sons and a daughter.

COMMUNIQUE

November 24, 1944.

To the Editor:

My next address should be A.P.O. ** as my unit has gone there for "staging" ?, perhaps. I was left behind to take care of the "left-behind" group of men. Mail service is, of course, almost non-existent here now.

We had our Thanksgiving turkey dinner on November 21st and was it good! Yesterday, I spent on the island where the ** have their headquarters with the natives. I may have written you some of this before but I hope not. I trust you will find the medical part of it interesting. ** is divided into three parts like this (diagram). At No. 1 is a large native hospital run by a medical corpsman, a lieutenant; at No. 2, where I am, there is a 150-bed hospital, run by a sergeant, and at No. 3, the same, run by another sergeant. These men are supposedly responsible for the medical care and teaching of sanitation for all the villages in their district, but seldom do they get to the deeper inland villages, too tough going and too dangerous.

These medical corpsmen have two and one-half years at the ** missionary school, 80 per cent medical training, then three months each at the dental school for extractions and with the ** native hospital for minor surgery and tropical disease study.

They give a concentrated course and are usually adept, interested and ingenuous. The man here has three natives ("Red Cross boys"—"Doctor boys") who give about 100 intravenous mapharsenes three times a week. Two of them can give intravenous sodium pentothal under supervision, or ether, quite adequately. One of them keeps a beautiful set of records. The most major surgery the sergeant does is the debridement of the huge tropical ulcers, cauterizing them with 40 per cent formalin, flushing copiously with water, loosely packing with vaseline gauze, and applying a thick cast, as in the Orr treatment, letting it alone until the smell is too offensive. Yesterday I made rounds on his 120 patients and the effect of the old ulcers of yaws is terrific. The natives, unlike our own colored people, have no sense of gratitude with a few exceptions, one was a "Mary," whom I operated on for frozen pelvis six weeks ago (probably the result of having been a maid in white man's home in **).

The hospital is three large thatched-roof buildings with the inevitable 2-foot high benches running along the walls, 7 feet wide, that they sleep

on. One is for "Marys" alone. A fairly decent minor surgery exists but the ** standard of sterilization is not ours, or, I should say, at least out here.

Upper respiratory infections are common and rather severe among these people. Binding the infant's head with bark, cloth, dyed and painted, is now forbidden but they do it anyhow. These natives are all pin-headed from it. Their hair is dyed with peroxide, atabrine solution or a red dye occasionally.

Must close. Best of regards to all our friends.

As ever,

John J. Monfort, Capt., M.C.

COMMUNIQUE

September 11, 1944.

To the Editor:

Just before the invasion of Europe I was transferred to the ** Auxiliary Surgical Group. Please change my address to the one above.

The surgical teams are attached to field hospitals. We take care of the seriously wounded non-transportable patients. I am giving the anesthetics for our team.

Some time ago I was in **. It is the same gay city. The Americans have taken over several hotels and you can get a free room and meals.

Sorry I did not get the May issue of The Journal. You asked me to let you know if I did not get my copy.

It is beginning to look like the war here will soon be over. We all hope so. Most of the officers in this organization were in Africa and Sicily. There is some rumor of sending us to the Pacific.

Best regards,

Max Hughes, Capt., M. C.

COMMUNIQUE

October 24, 1944.

To the Editor:

Your letter of September 30th, September "Random Thots" and the October issue of The Journal arrived two days ago. Thanks for mailing the extra copy of The Journal for May.

Jabez Jackson must be in this area. I hear the ** is at **. I also know the Germans are throwing some flying bombs in this vicinity. Perhaps it is safer to stay nearer the front and visit Jabez after the war.

Regards,

Max Hughes, Capt., M.C.

RESOLUTIONS OF RESPECT

"There are stars that go out in the darkness
 But whose silvery light shineth on,
 There are roses whose perfume still lingers,
 When the blossoms are faded and gone.
 "There are hearts full of light and of sweetness
 When no longer their life current flows,
 Still their goodness lives on with the living
 Like the souls of the star and the rose."

In Memory of Clyde L. McNeil,
 who died November 24, 1944

Once again death hath summoned a beloved member, and the golden gateway to the Eternal City has opened with a welcome to home. The work of ministering to the wants of the afflicted, in shedding light into darkened souls and in bringing joy into the places of misery is completed, and as a reward has received the plaudit, "well done" from the Supreme Master.

"Their toils are past, their work is done,
 And they are fullest blest;
 They fought the fight, the victory won,
 And entered into rest."

And Whereas, The allwise and Merciful Master has called our beloved and respected member home;

And Whereas, Having been a true and faithful Member of our Organization, therefore, be it

Resolved, That The Benton County Medical Society, Benton County, Arkansas, in testimony of its loss, that we tender to the family of our deceased Member our sincere condolences in their deep affliction and that a copy of these resolutions be sent to the family.

A. J. Harrison, Pres.
 Geo. M. Love, Sec'y-Treas.

WOMEN'S AUXILIARY NEWS

War Service Program

The War Service Committee was created by a resolution passed by the House of Delegates at the annual meeting of the Women's Auxiliary to the American Medical Association in Chicago, June 7, 1943.

After consulting with the Advisory Council about the war service that had been done previously by state auxiliaries, the chairman of this committee prepared a program for the coming year which includes the most essential war activities for Auxiliary members.

In developing this program, each member of the Auxiliary, as an American citizen, must assume her responsibility in the total war effort,

and it should be remembered that we function as an Auxiliary to the American Medical Association and not as an independent organization.

Our program of war activities as an Auxiliary should be one of assistance to them in their excellent programs now established.

Our Auxiliary should work as closely as possible with the state war participation committees or with similar committees of the State Medical Society.

It is suggested that Auxiliary members participate in the following activities: The sale of U. S. War Bonds and Stamps; Hospital Service, and this includes Staff Assistance, Technicians, Occupational Therapy, Nurses Aide, Grey Ladies, Typing, Filing and Bandages; Doctors Aide Corps; Minute Maids; Day Nurseries; Study of Nutrition and Distribution of Food; Serving as Hostesses at U. S. Camps; Assisting at Canteens and Ration Boards; U. S. Cadet Nurse Corps; Red Cross and this includes Sewing and Knitting, First Aid, Home Nursing, Typing and Filing, Assisting in Drive for Funds and Blood Banks.

Mrs. Homer A. Higgins,
 War Service Chairman.

The Women's Auxiliary to the Bowie and Miller Counties Medical Society met Friday afternoon at the home of Mrs. H. E. Murry, with Mrs. L. H. Lanier and Mrs. Joe Tyson as hostesses.

Mrs. William Hibbitts presided in the absence of the president, Mrs. J. T. Robison.

The Christmas dinner will be held at Hotel McCartney, December 15th, in conjunction with the members of the Medical Society. Dr. Guy Witt, neuro-psychiatrist, of Dallas, will speak at the dinner.

Members of the Auxiliary will serve in the Bond Booth December 7th.

Mrs. Ben Tucker reviewed "The Book Nobody Knows" (Bruce Barton). During the social hour, refreshments were served from the dining table which was centered with a silver bowl of mixed chrysanthemums. Mrs. L. J. Kosminsky and Mrs. William Hibbitts presided.

Those present were Mrs. Roy Baskett, Mrs. E. L. Beck, Mrs. Allen Collom, Jr., Mrs. C. H. Franks, Mrs. William Hibbitts, Mrs. C. E. Kitchens, Mrs. J. H. Rives, Mrs. Joe Tyson, Mrs. E. M. Watts, Mrs. N. B. Daniel, Mrs. R. R. Kirkpatrick, Mrs. L. J. Kosminsky, Mrs. A. G. Lee, Mrs. Peacock, and Mrs. P. H. Phillips, both of Ashdown.

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BOOK REVIEW

Dictionary of Gynecology and Obstetrics. By Clarence Wilbur Taber, M. D., with the collaboration of Mario A. Castallo, M. D., F.A.C.S. Illustrated. Philadelphia: F. A. Davis Company, 1944.

The service which this book attempts is more satisfactorily presented in a good general medical dictionary.

Medical Diagnosis. By Roscoe L. Pullen, A. B., M. D., Instructor in Medicine, Tulane University of Louisiana School of Medicine; Assistant Clinical Director, Charity Hospital of Louisiana at New Orleans; formerly Fellow in Clinical Endocrinology, Duke University School of Medicine and Duke Hospital, Durham, North Carolina. With a Foreword by John H. Musser, B. S., M. D., F.A.C.P., Professor of Medicine, Tulane University of Louisiana School of Medicine; Senior Visiting Physician, Charity Hospital of Louisiana at New Orleans. 1,106 pages with 584 illustrations and 12 colored plates. Philadelphia and London: W. B. Saunders Company, 1944. Price \$10.

This excellent text has numerous well-informed contributors. It stresses subjects which are most valuable to the general practitioner. The examination of the heart and electrocardiography occupy 129 of a total of 1,063 pages in the book. This section is well-written and practical in application. The chapter on the neurological examination emphasizes the important features in this examination, enabling the physician to quickly review the technic and interpretation of neurological findings. This text can be offered to the general practitioner without reservation but lacks some qualities considered desirable for the student.

Manual of Military Neuropsychiatry: Edited by Harry C. Solomon, M.D., Professor of Psychiatry, Harvard Medical School, Medical Director at the Boston Psychopathic Hospital; and Paul I. Yakovlev, M.D., Clinical Director, Walter E. Fernald State School, Instructor in Neurology at the Harvard Medical School. With the collaboration of 11 doctors. 764 pages with 15 illustrations. Philadelphia and London: W. B. Saunders Company, 1944. Price \$6.00.

While this Manual of Military Neuropsychiatry is edited by Drs. Solomon and Yakovlev, it is a compilation of chapters written by leading neurologists and psychiatrists throughout the United States. There are forty-five of these contributors. This feature of the work alone insures the worth of the volume.

This book is primarily intended as a reference work on topics of clinical neurology and psychiatry. While it was especially prepared for medical officers in the service, yet it should prove invaluable to all physicians on staffs of all institutions caring for mental and nervous patients. Also, it will prove serviceable to all physicians who have psychiatric and neurological problems arising in their practice, especially during the period following the close of the emergency when they are called upon to pass upon and treat neuro-psychiatric cases among the discharged soldiers.

Plaster of Paris Technic: by Edwin O. Geckeler, M. D. Pp. 220. Price \$3.00. Baltimore: The Williams and Wilkins Company, 1944. This is a needed volume with the technic of plaster of paris application well described and illustrated. Of particular value is the chapter dealing with common errors and difficulties and means to avoid these. The book will be of interest and value to every one who has occasion to use plaster of paris.

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A BRIEF SUMMARY OF THE MODERN CONCEPTS OF ACQUIRED SYPHILIS *

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The great period of discovery for modern syphilology was during the period 1905-1910. During that brief period, the organism *treponema pallidum* was discovered, as well as the complement fixation serologic test and arsphenamine. A few years later, bismuth replaced mercury in the scheme of treatment. The still more sensitive serologic flocculation test was then introduced. With these new weapons, physicians began the long, arduous task of developing and standardizing the techniques of diagnosis and treatment.

During the period 1913-1916, special syphilis divisions were organized in various medical clinics and large hospitals because of the general recognition of the fact that the therapy of syphilis as then practiced in a dozen or more separate clinics was utterly unsatisfactory. Patients were being treated by widely varying methods because of individual manifestations of the infection. Such chaos provided little opportunity for the adequate study of syphilis as a disease problem. Under the organized clinic groups of later years, it was soon realized that syphilis with its variety of manifestations was and is primarily a medical problem rather than one of a urologic, dermatologic or neurologic nature. Since 1916, and to this date, many clinic groups, including the Cooperative Clinic Group, have advanced clinical and laboratory procedures as well as methods of treatment and research.

As a result of the cooperative efforts, we today are in possession of the comprehensive clinical classification of syphilis which is accepted and standard.

(A) Primary Syphilis: Chancre (Invasion).

(B) Secondary Syphilis: Mucocutaneous lesions (Invasion).

(C) Latent Syphilis: Showing no evidence of primary, secondary or late manifestations (Hidden). (a) Early Latent Syphilis is a latent case: (1) with a history of early lesions less than four years before; or (2) in absence of history, 25 years of age or younger. (b) Late Latent Syphilis: Is a latent case: (1) with history of early lesions more than four years before; (2) in the absence of history, 26 years of age or older.

(D) Late Syphilis is any case showing late manifestations such as gummata, late ocular syphilis, neurosyphilis, cardiovascular syphilis or osseous syphilis.

Those who treat syphilis should have an understanding as to what happens, biologically speaking, to an individual who acquires the disease.

It has been determined that within a few hours after inoculation, treponemes could be demonstrated in regional lymph nodes (24 hours, Brown and Pearce; 5 minutes, Kolle). Immediately after inoculating animals, they can be recovered from circulating blood (Raiziss and Severac), indicating their rapid spread both by the blood stream and the lymphatics.

Charpy demonstrated treponemes in a completely healed penile lesion which had occurred during coition two weeks before. Frankl recovered treponemes from the apparently normal skin of two patients 4 and 6 days respectively after the appearance of the chancre.

As the generalized spread of the organisms is taking place, there is also occurring a multiplication at the inoculation site, where there appears, after an incubation period ranging from 10 to 90 days, but averaging 3 weeks, a characteristic tissue reaction known as primary syphilis, the chancre. Simultaneously, or shortly thereafter, there appears, in most of the cases, a painless, rubbery enlargement of the regional lymph nodes, the satellite bubo. These signs last a few days or weeks, and, except for residual induration of the bubo, heal spontaneously.

As soon as possible, the treponemes leave the blood stream, which is not a suitable medium for growth, for the more favorable environment of the tissues of ectodermal origin, notably the skin,

*Read before the Sixty-ninth Annual Session, Arkansas Medical Society, Little Rock, April 18, 1944.

mucous membranes, eye and nervous system. The deposited treponemes undergo a second period of local multiplication which, after a period of about 6 weeks following the primary or chancre stage, culminates in the secondary outbreak with its diversity of lesions. The secondary lesions, as well as the chancre, contain large numbers of easily demonstrable organisms. This secondary stage is further characterized by the fact that there is little or no destruction of tissue. These lesions too, even without treatment, heal and disappear spontaneously within a few days or a few months without leaving any permanent scars. Although all cases do not pass through the classified secondary stage, a high percentage of cases do.

A series of recurring lesions may occur after the spontaneous healing of the secondary outbreak. The recurring lesions more often are limited to the skin and the mucous membranes of the mouth or genitalia. The relapsing lesions contain treponema and are highly infectious. In most cases, the relapsing lesions cease to occur by the time that 3 to 5 years have elapsed. This period constitutes early latency and is considered as an infectious period. The patient then enters a period varying from a few months to a lifetime, during which there is no sign of syphilitic infection. During the period of latency (early and late) there is usually no outward sign of syphilitic infection. The presence of the disease is recognizable if at all only by means of serologic tests of the blood.

The tissues of the host undergo varied reactions during the period of early latency and late latency or late syphilis. Two sets of phenomena may be taking place beneath the outward non-symptomatic serene surface. There may be a slow progressive inflammation, mild and definitely chronic in various invaded tissues with subsequent fibrosis. There may also be a violent inflammatory reaction with marked tissue destruction resulting in gummata. There is no known reason why one patient develops late lesions and another does not, nor why they appear when they do.

The late lesions of syphilis, then, may be of two types: the explosive, destructive, allergic reaction of gumma; or the physiologic breakdown of important structures, especially cardiovascular or central nervous systems, from the effect of perivascular inflammation and fibrosis.

Those cases of symptomless infection wherein the patient completely escapes the early lesions of the disease are the most baffling from the standpoint of infectiousness, diagnosis and treat-

ment, as they form an inexhaustible reservoir for infectious carriers and for the development of serious late manifestations.

It has long been common knowledge that many persons with late syphilis (30 per cent or more of all males, 60 per cent of all females) could give no history of infection. It is well known that in some patients the lesions of early syphilis are wholly insignificant or absent. The trivial, fleeting chancre, which resembles an abrasion; the hidden cervical chancre in women; the tiny, painless mucosal lesion; the very faint secondary rash—these may be all so trivial as to escape the patient's notice entirely, or so like other familiar clinical phenomena as to be misinterpreted and in either case to fade completely from memory. Physicians repeatedly have discovered lesions of early syphilis in patients who were wholly ignorant of their presence.

Just how frequently symptomless infection occurs is impossible to determine, but it is believed that at least one man of every five and one woman of every three who acquires syphilis does so without ever developing any lesions recognizable as early syphilis. Symptomless infection from the treatment standpoint is of two-fold importance to both the community and the individual. Such symptomless cases of syphilis are a public health menace conceivably greater than patients with frank early lesions, since they may act as carriers of the disease. Unrecognizable as syphilitics, even to themselves, they unwittingly spread disease to others. At present, there is no satisfactory method of approach to the public health question involved, except an increasingly widespread routine use of serologic tests, with adequate sterilizing treatment of those found to be infected.

Primary Syphilis

The diagnostic maxims:

1. Any genital sore in male or female is possibly primary syphilis until proven otherwise.
2. Any indolent lesion anywhere on the body (especially lips, tonsils, fingers) which fails to heal in two weeks, may be primary syphilis.
3. The diagnosis of primary syphilis is a laboratory, not a clinical, procedure.
4. Do **not** treat suspected primary syphilis **locally** until repeated darkfields (3 to 6) on consecutive days are negative.
5. Do not give antisyphilitic treatment on suspicion; prove the diagnosis.
6. There is reason for haste in diagnosis; hours count.

These maxims are sufficiently self-explanatory as to require no further expansion. If they were

generally applied, the proportion of patients coming under treatment for primary (especially sero-negative primary) rather than secondary syphilis would be enormously increased. Sero-negative primary syphilis has a 20 per cent greater chance of cure than sero-positive primary syphilis. Unless the darkfield examination is done by a qualified and competent clinician, pathologist or technician, many errors in early diagnosis will be made. The suspected primary case should be referred in person to one of the above for a darkfield examination unless the private physician is well-trained in the darkfield technique. The mailing of capillary tubes filled with serum taken from the suspicious lesion to a recognized laboratory for diagnosis is not as satisfactory as examination of the fresh serum because of the time element. Proof demands the demonstration of treponema in the open lesions or lymph nodes or the presence of a positive serologic reaction.

Diagnose primary syphilis by:

1. Darkfield of surface serum; if negative, repeat three to six times on consecutive days before local treatment.

2. If surface darkfield is negative, do darkfield of aspirated serum from lesions base or do darkfield of aspirated serum from regional lymph node.

3. If you have no darkfield microscope, send the patient at once to someone who has; or send a capillary tube specimen to your nearest laboratory.

4. Do a serologic test at the first visit. If any of the tests are positive, begin treatment at once. If all are negative:

5. Do serologic test follow-up for three months, weekly for the first month, every two weeks thereafter.

Secondary Syphilis

The diagnostic maxims:

1. Do blood serologic follow-up for three months on any lesion which was possibly primary syphilis.

2. For any generalized skin eruptions do a serologic test.

3. For any sore mouth or throat which does not heal in 10 days, do a serologic test.

4. For any patchy loss of hair, do a serologic test.

5. For any iritis, neuro-retinitis, vague bone pains, poly-articular arthralgia, acute, subacute or chronic infectious arthritis, **do a serologic test.**

The clinical diagnosis of secondary syphilis, often extraordinarily difficult for even the expert, will be greatly simplified if the above maxims are adhered to.

The first of these—the serologic follow-up on any lesions which might have been primary syphilis—takes into consideration two important points: that it is highly desirable to recognize secondary syphilis before it develops (the serologic test always becomes positive before the development of the lesions) and the lesions of secondary syphilis may be either completely lacking or so trivial as to be overlooked by patient and physician. The next four maxims point to the fact that the common lesions of secondary syphilis are five: generalized skin eruptions, mucosal lesions, alopecia, iritis and arthralgia. There are other manifestations which may occur, but in comparison with the five, they are rare. Ninety-five per cent of all patients with secondary syphilis will present one or a combination of these five manifestations. The maxims also emphasize that clinical differentiation of these lesions from other conditions is often difficult or impossible and that diagnostic safety depends entirely on the physician suspecting secondary syphilis when any of five manifestations occur and that he check his suspicion by a blood serologic test for syphilis. Fortunately, for accuracy of diagnosis during the stage of secondary syphilis the serologic test is always 100 per cent positive. If it is negative, there is practical assurance that the clinical suspicion was wrong and the patient has some other disease.

Diagnosis vs. Case-Finding in Early Syphilis

Even though the physician recognizes all the lesions of early syphilis when he is consulted, it does not suffice from the public health standpoint and from that of the individual patient. Many freshly infected individuals do not consult the physician at all, because of ignorance or negligence, or because infection may be so completely symptomless or the symptoms so trivial that he is unaware of his disease. These patients must be sought out, they must be found.

The case-finding of early syphilis is even simplified from that of tuberculosis, typhoid fever and any other communicable disease, because syphilis is spread from person to person rather than indirectly. Case-finding in early syphilis reduced to its simplest form is (1) From whom did you get syphilis? and (2) To whom have you given syphilis? The wording of the two questions is to impress the physician; they are not the form in which the patient should be addressed. The patient is asked, in the vernacular if necessary: "With whom have you been exposed by sexual intercourse, or by kissing, during the three months preceding the appearance of the 'sore' or chancre?" "With whom have you been ex-

posed in similar fashion since the 'sore' or chancre appeared?" From any member of the first group the patient may have acquired syphilis; to any member of the second group he may have transmitted syphilis. All individuals in both groups should be examined for syphilis clinically and by serologic test. This is the unavoidable responsibility of every physician who makes the diagnosis of early syphilis. It goes without saying that the physician is unlikely to obtain this information without first gaining the patient's confidence, explaining the reasons for the inquiry and assuring the patient of secrecy and the safeguarding of his identity. The patient must be told with complete frankness the nature of his illness as soon as the diagnosis is established. The most desirable procedure is for the patient himself to persuade his contact or contacts to consult the physician. Failing this, he is often willing to supply the names and addresses of contacts who may be approached either through the agency of trained workers provided by your health department or by the physician himself. Upon request by the physician, health workers will interview contacts and refer them to the physician with a complete report of the interview. The utmost gentleness and tact in dealing with such contacts is essential to success.

Early Latent and Late Latent Syphilis

Latent syphilis is hidden syphilis. Latency begins with the healing (spontaneous or under the influence of inadequate treatment) of early syphilis, and extends for a variable period of time ranging from a few months to a lifetime. There is no way to recognize non-symptomatic or clinically negative latent syphilis except by serologic tests. Modern serologic tests are 90 to 95 per cent efficient in detecting untreated latent syphilis.

What has been said of latent syphilis can be said of prenatal syphilis. In the vast majority of syphilitic pregnant women, syphilis cannot be detected or recognized even by the most expert, except by a routine serologic test of the blood, since few syphilitic women have lesions and the fact that history and physical examination are nearly worthless in the diagnosis of the group.

For classification purposes, early latent syphilis is syphilis under 4 years' duration. Late latent syphilis is that which exceeds 4 or 5 years' duration. Many late manifestations of the disease may be found during the time period of either early latent or late latent syphilis.

The recognition of clinically negative latent syphilis is more a matter of case-finding rather

than one of diagnosis. In the vast majority of patients with latent or late syphilis, the serologic test is done not because of a positive history of infection (at least 50 per cent fail to give such a history), nor because the examining physician suspected syphilis on the basis of symptoms or signs, but instead, because the patient was fortunate enough to fall into the hands of a physician or hospital where such tests are routine.

For many years now, the serologic test has been obligatory in our better hospitals for both in and out-patient services. If this system were adopted by every hospital in the country, to say nothing of private practice, it is estimated that the number of patients with syphilis recognized and brought under treatment each year would be increased from 1,000,000 to 3,000,000. What this would mean to our syphilis control program and to the patients themselves is apparent.

Late Syphilis

Late syphilis is characterized by a wide diversity of location and extent of lesions, involving almost any structure in the body, often disturbing vital functions. It is obviously impossible, without far exceeding the bounds put on this brief summary, to consider all possible lesions. Fortunately, 95 per cent of all patients with late syphilis develop lesions in one or more of six systems—the mucocutaneous structures, the bones and joints, the liver, the heart and aorta, the eye or the nervous system.

Late Cutaneous Syphilis

The physical characteristics of late cutaneous syphilis are summed up in the following basic characteristics of late syphilis:

1. Solitary or few lesions.
2. Asymmetry.
3. Induration; deep palpable infiltration.
4. Indolence; low grade inflammatory process.
5. Arciform polycyclic borders forming segments of circles.
6. Sharp margination; "punched out" ulcers.
7. Tissue destruction and replacement with or without ulceration.
8. Central or one-sided healing with peripheral extension.
9. Superficial, atrophic, non-contractile scar with arciform configuration of original lesion.
10. Persistent peripheral hyperpigmentation.

These clinical characteristics are, however, often inadequate since confusion arises by virtue of the fact that no less than 27 skin diseases other than syphilis may commonly possess one or more of the above clinical characteristics; they

range from such trivialities as trauma and boils to such gravities as epithelioma, leprosy and fungus infections. Confronted with any skin lesions which possess one or more of the above characteristics, the physician is on relatively safe ground only if he does a routine serologic test. Here again, the serologic test is 95 per cent efficient. In the few cases missed by the serologic test, clinical suspicion may be checked by a therapeutic test with a single dose of arsphenamine. If the lesions show evidence of prompt healing, they are probably syphilis; if no healing occurs within 5-10 days, they are probably some other disease or condition.

Late Osseous Syphilis

Diagnostic errors are less frequent in late cutaneous syphilis than in late osseous syphilis. There are ten diagnostic maxims here which every physician, regardless of his specialty, should know:

1. Routine serologic test in all patients with bone or joint symptoms (excluding fractures), especially "subacute or chronic infectious arthritis."
2. Examine patient completely—not only the lesion. Look for associated skin lesions and scars.
3. Suspect tibial, skull and shoulder girdle lesions.
4. Syphilitic bone pain is usually nocturnal.
5. X-ray is important in diagnosis but a negative report does not exclude inflammatory or early lesions.
6. Do not operate or incise for diagnostic purposes until the serologic report is in hand.
7. Suspect syphilis in the "won't heal" syndrome of fractures.
8. Suspect osteitis of the skull in severe nocturnal headache—X-ray the skull before expirating foci of infection.
9. Suspect Charcot joint in every "hypertrophic arthritis" especially of the knee.
10. Suspect early acquired or late congenital syphilis in bilateral hydrarthrosis of ankles or knees.

Early or late osseous syphilis may resemble at least 33 other diseases or conditions varying from nose-picking to neoplasms and brain tumor. Diagnostic difficulty will be resolved in 95 per cent of the cases through the serologic test which should be included at first in the patient's study and most certainly so unless the diagnosis is clearly other than syphilis or if the chosen therapeutic measures do not afford prompt relief. No operations on bones or joints (except for fractures or dislocations) should ever be undertaken until the serologic report is at hand.

Late Ocular Syphilis

Kerato-iritis, neuro-retinitis, chorio-retinitis and optic atrophy (primary, secondary or retro-bulbar) are the common lesions of late syphilis of the eye. Any or all of these lesions resemble similar lesions, due to many other causes. However, any patient who consults the ophthalmologist for any one of the conditions is entitled to a complete investigation for syphilis, the first step of which is of course the serologic test for syphilis. Blindness could often be prevented if the ophthalmologist thought of syphilis first, instead of last.

Cardiovascular Syphilis

The recognition of uncomplicated aortitis before the development of aortic regurgitation or saccular aneurysm is the therapeutic hope in cardiovascular syphilis. While uncomplicated syphilitic aortitis is often clinically unrecognizable, it may nevertheless be diagnosed correctly in a number of cases.

The diagnostic maxims of uncomplicated syphilitic aortitis are:

1. X-ray and fluoroscopic evidence of aortic dilatation, especially if localized to the ascending aorta.
2. Increased retromanubrial dullness.
3. A history of circulatory embarrassment, especially exertional dyspnea, with or without progressive cardiac failure.
4. A tampanitic, bell-like quality to the second aortic sound.
5. A rough systolic aortic murmur, usually transmitted upward, downward or both.
6. Substernal, dull, aching pain, usually without radiation or relation to exercise.
7. Paroxysmal dyspnea, not exertional and usually nocturnal.

In a patient known to have syphilis, whether treated or not, the presence of any three of the above maxims makes almost certain the diagnosis of uncomplicated aortitis. The presence of any two, provided mitral disease be absent, makes the diagnosis likely. The signs and symptoms of cardiovascular syphilis may be closely imitated by other forms of heart disease. Essential hypertension and aortic arteriosclerosis may closely mimic uncomplicated aortitis; rheumatic aortic regurgitation is often impossible to distinguish clinically from the syphilitic variety. Mediastinal tumor may be confused with saccular aneurysm. The only safe procedure is to suspect syphilis in all such cases and to check the suspicion by a serologic test.

Neurosyphilis

Invasion of the nervous system by the treponeme probably occurs in all patients with syphilis and, unless the course of the disease is influenced from without (by treatment), this takes place in most, if not in all, instances within the first year after infection. The importance of routine lumbar puncture and the absolute necessity of carrying it out in every patient with syphilis, early or late, is apparent from the fact that spinal fluid abnormalities antedate the appearance of obvious clinical damage in the nervous system by many years. The potential parietic or tabetic patient is recognizable within the first year of infection, rather than 15 years later, when extensive harm may already have been done.

The latent neuro-syphilitic can only be discovered by means of the routine spinal fluid studies. If spinal fluid abnormalities are present in the absence of clinical evidence of neurosyphilis, the condition is known as asymptomatic neurosyphilis. Through the character of changes in the spinal fluid, asymptomatic neurosyphilis may be classified into three groups:

Group I—Minimal		
Cells 4-12	Globulin 0—+	Wass.—
Colloid 0000000000		
Group II—Intermediate		
Cells 8-40	Globulin +++	Wass.+
Colloid 3322221000		
Group III—Paretic		
Cells 80-100	Globulin++++	
Wass.++++	Colloid 5555210000	

The Kolmer or Wassermann reaction, the cell count and the amount of globulin or protein in the spinal fluid are the key to properly evaluating and classifying the type group of the spinal fluid. A positive spinal Wassermann with a cell count of 60-200 and a protein of 80-200 regardless of the colloidal curve warrants immediate and intensive treatment for neurosyphilis.

Neurosyphilis may be classified on the combined clinical and anatomic basis proposed by Head and Fearnside which divides patients into four groups relative to the extent of the pathologic lesion being predominately meningeal; vascular; parenchymatous and the inflammatory or degenerative basis:

1. Meningeal neurosyphilis, usually early.
2. Vascular neurosyphilis, may be early or late, usually late. Syphilitic cerebral endarteritis leads to cerebral vascular accidents, hemiplegias, paraplegias, subarachnoid hemorrhages, etc.
3. Diffuse meningovascular neurosyphilis, in which the lesions are a mixture of meningeal and

vascular involvement. This group includes such widely diverse disease entities as brain gumma, syphilitic epilepsy, diffuse "cerebrospinal" syphilis and late asymptomatic syphilis.

4. Parenchymatous neurosyphilis, including tabes, paresis and primary optic atrophy. The first two inflammatory, the latter degenerative.

The spinal fluid will reveal abnormalities in most instances many years prior to the development of clinical signs and symptoms of neurosyphilis. Through the early spinal puncture and spinal fluid examination, it is even possible to predict with some degree of accuracy whether the subsequent involvement will be parenchymatous (tabetic or parietic) or meningovascular in type. It is possible, in most instances, through early spinal fluid examination during the period of asymptomatic involvement to prevent the development of symptomatic neurosyphilis through adequate treatment.

The Prognosis of Untreated and Treated Syphilis

Untreated primary and secondary syphilis is highly infectious. It is assumed that after lesions have developed, the danger of direct transmission to others is greatest within the first year, is still great during the second year and is rapidly less so as further time passes. By the end of the fourth or fifth year, the risk of infectiousness is slight whether the patient is treated or untreated.

Treated primary and secondary syphilis is immediately rendered noninfectious. Two to seven doses of a trivalent arsenical will render the most infectious case noninfectious for a period of months.

Syphilis is "curable"; early syphilis in the biologic sense and late syphilis in the symptomatic sense. It has been estimated from reliable clinic group studies and follow-up over a period of years that possibly 1-2 infected patients out of 100 will eventually cure spontaneously without any treatment; 23-30 will develop late lesions which will incapacitate or kill; 12-20 will develop the more benign late manifestations; 50-60 will probably pass through life unharmed, so far as they themselves are concerned.

Although the above data is very encouraging as to the patient's chances, it must be remembered that all early cases are infectious. The transmission of infection to others is a compelling reason for treatment even if modern chemotherapeutic and chemothermic therapy advances had not altered completely the character of ultimate results.

The expected prognosis of inadequately treated and untreated patients is practically the same.

Insofar as the ultimate outcome for the patient, inadequate treatment is often of more serious consequences than no treatment at all. The freshly infected individual acquires a degree of natural immunity as the disease progresses. If the desirable early treatment is instituted, that natural immunity is broken or inhabited. If treatment is stopped, irregular or inadequate, while foci of organisms remain in the body, and the patient is left without defense against them, they may multiply in situ, or be redistributed throughout the body as if freshly introduced from without. Under such conditions, infectious cutaneous or mucosal relapse is more common in early syphilis inadequately treated than untreated.

The incubation period of late neurosyphilis (tabes, paresis and meningovascular syphilis) is definitely shortened in patients whose treatment for early syphilis was inadequate. In late syphilis, the worse to be expected is that inadequate treatment may not halt the progress of the late lesion present, and that continued progression rather than relapse will occur.

Of early cases inadequately treated, 35-40 per cent will develop serious late syphilis; 15 per cent will develop late benign syphilis; 30 per cent will develop latent syphilis; only 15-20 per cent will be "cured."

Adequate treatment completely alters the picture. The sero-negative primary cases will approximately 100 per cent cures; sero-positive primary and secondary cases will approximate 85-95 per cent cures. Of all early cases adequately treated, only 1-5 per cent will develop serious late syphilis; 0-2 per cent will develop benign late syphilis; 2-5 per cent will develop latent syphilis.

The prognosis of early syphilis is definitely improved if treatment is aimed at the disease. In late syphilis, one must concentrate the regime of treatment on the patient to alleviate symptoms and progress of the disease.

The Criteria of Cure

Inasmuch as there is as yet no definite single test which can be applied to determine the fact of "cure" it is necessary to fall back on prolonged clinical observation. The real test of "cure" is the fact that the patient remains free of clinical or serologic signs of syphilis, and that he does not infect others.

The point at which treatment may be safely discontinued depends on the regularity and adequacy of treatment, negative serology and spinal fluid and on the presence or absence of serologic or clinical relapse.

When treatment is stopped, the patient must understand that determination of the probability of "cure" depends largely on his clinical and serologic behavior during the first year thereafter. To qualify for "cure" he must, within this period of time:

1. Take no treatment of any kind.
2. Develop no lesions of syphilis.
3. Maintain a negative blood serologic test, which should be checked at least every two months during the year.
4. At the end of the year, complete physical examination must be negative to any abnormalities attributable to syphilis. The negative physical findings must be checked by a repeat negative test of the cerebro-spinal fluid.
5. Until five years have lapsed after adequate treatment, the blood serologic test should be checked every three months and complete physical examination every six months. Complete normality for 5 years after the cessation of treatment probably implies permanent "cure."

Treatment

In **early syphilis**, treat the disease, through adequate, regular, continuous treatment; stop and "cure" the disease; effect radical "cure."

In **late syphilis**, treat the patient, through regular, continuous treatment, alleviate the patient's symptoms and prevent further progression of the disease.

The so-called prolonged "rest period" in the treatment of syphilis should be eliminated entirely, as such predisposes to relapse.

It is important to the successful outcome of the case that an intelligent plan of regular treatment be formulated and followed throughout until adequate treatment has been completed and desired results obtained.

Courses of (8-12) arsenicals should be alternate and overlapping with courses of (8-12) heavy metal (bismuth) until a total of at least 30 arsenical and 20 heavy metal injections have been administered.

Arsenical preparations, through their treponemocidal powers, destroy the invading treponema pallidum.

Bismuth preparations are an important aid in that they are both treponemocidal and treponemostatic in effect. There is also some thought in the belief (Stokès) that bismuth stimulates the defense mechanism of the host.

Certain arsenical and bismuth preparations are more toxic than others. Here, as the drugs of choice, we will consider only those less toxic which still maintain the maximum treponemocidal effect.

The more powerful preparations will not be considered as they are impracticable; thus the preparations of mercury salts are eliminated from this discussion.

Drugs of Choice in Primary, Secondary, Early Latent Syphilis

Arsenicals: Mapharsen, Phenarsine Hydrochloride, Neoarsphenamine, Arsphenamine and Bismarsen.

Heavy metals: Bismuth subsalicylate, Stabisol, and Bismarsen.

With exception to Bismarsen, the arsenicals above mentioned are administered intravenously, the heavy metals intramuscularly. Bismuth preparations in peanut oil suspension are less painful to the patient.

As to the dosage of the arsenical drugs to be given to the average patient with early syphilis, it must be kept in mind that maximum treponemical attack is desired from the outset. The initial dosage should not be small with gradual step-like increases until the average therapeutic dose is reached. By this system there is practical danger of producing a drug-fast strain of organisms.

On the basis of a 150-pound male, the first three doses of arsphenamine should be 0.6 gm., neoarsphenamine, 0.9 gm., mapharsen, .06 gm. After the first three injections, the average therapeutic dose of mapharsen is .06 gm. for men and .04 gm. for women, arsphenamine 0.4 gm. for men and 0.3 gm. for women, neoarsphenamine 0.9 gm. for men and 0.6 gm. for women. The dose of bismuth in oil should be .20 gm. (2 cc.).

The more serious reactions of dermatitis, jaundice and encephalitis are as frequent on small dosages as large dosages. The reactions are more frequent after use of neoarsphenamine than arsphenamine. Their still greater decreased incidence after mapharsen or phenarsine hydrochloride is a very strong point in favor of the use of those drugs.

In summary, the principles of treatment of early syphilis, including early latency, are as follows:

1. The aim of treatment is radical "cure."
2. Study the patient before treatment to determine: (a) Complications of syphilis; (b) other complicating diseases; (c) base-line physical findings to compare with subsequent examinations.
3. Examine contacts.
4. To secure maximum treponemical effect use: (a) Mapharsen, phenarsine hydrochloride or neoarsphenamine in place of other arsenicals (30 doses) or approved intensive rapid treatment;

(b) bismuth in place of mercury (30 doses); (c) concentrate on maximum arsenical dosage and regularity during the first three months of treatment.

5. Treatment must be continuous—no rest periods.

6. Use the arsenicals and heavy metals in alternating courses or in rapid treatment, they may be used in combination.

7. Utilize early serologic control, including cerebro-spinal fluid, to determine duration of treatment.

8. Follow adequately treated cases with rigidly controlled year of probation.

9. Thereafter, follow patient for his lifetime (or for an absolute minimum of 5 years) with periodic physical and serologic examinations.

Late latent and late syphilis treatment is in contrast to that of early (under 4 years) syphilis in the fact that the aim is no longer radical "cure" but rather clinical arrest and the prevention of infection to others. At present, the frequency of sero-resistance and such meagre pathologic information as is available, indicate that late syphilis (over 4 years) is difficult to "cure" in the biologic sense. The aims of treatment are to prevent the infection of others (adults and unborn infants), alleviate symptoms and to reduce the probability of progression or relapse. These aims may be accomplished with less intensive treatment (arsenicals) than is required in early syphilis.

Two positive serologic tests, a spinal puncture and spinal fluid examination, should be accomplished prior to the beginning of treatment. Should the spinal fluid findings prove central nervous system involvement, the plan of treatment may differ from that of noncomplicated late latent or late syphilis.

In uncomplicated cases, the drugs of choice are the same as those in early syphilis. Continuous regular treatment again is necessary. Most cases derive "maximum benefit" from treatment on receiving 20-26 arsenical treatments and 30-40 bismuth injections.

The patient should first be prepared to receive arsenical therapy by a course of 6-8 injections of bismuth to prevent therapeutic shock, then courses of 8-12 arsenicals and heavy metals should be administered in an alternating, overlapping scheme until "maximum benefit" is reached.

It is a common experience for the late latent or late case to report a few weeks after starting treatment that although he had not been con-

scious of feeling badly before treatment, he now feels much better. This change represents genuine improvement in the systemic infection and is a sustained gain.

Treatment of Late Mucocutaneous Syphilis

Where the special lesions of cardiovascular, visceral or neurosyphilis do not complicate the treatment problem, the general plan of treatment as suggested for late latent syphilis should be adhered to. However, such patients require more treatment in terms of an arsenical drug, of heavy metal, and of total duration than the average patient with late latent syphilis. For late mucocutaneous syphilis in the adequate protection against relapse, a total of 7 courses each of an arsenical and a heavy metals is essential (56-60 arsenical, 56-60 heavy metals).

Objectively, there is rapid healing of skin lesions, even the largest, within 6-8 weeks. Skin lesions leave scars on healing, which are ineradicable. For a few months or even a year or more, they may be deeply pigmented. However, eventually the pigmentation fades to a degree and leaves some atrophy of the tissue.

Treatment of Late Osseous Syphilis

The same treatment plan as recommended for late latent syphilis applies, providing the special lesions of cardiovascular, neurosyphilis and visceral syphilis do not co-exist.

In patients with osseous lesions, the first injection of an arsenical drug is often followed within a few hours by an intense exacerbation of pain, lasting from 12-24 hours. In most instances, this exacerbation is in turn followed by prompt relief from all pain; the patient is symptom free, perhaps for the first time in months. This is more so true of periosteal lesions; if the whole bony structure is involved, disappearance of symptoms may require days and even weeks.

Little or no objective change takes place in proliferative osseous lesions; deformity, if present, is usually due to the deposition of new bone, which treatment will not remove. Sometimes surgical intervention is necessary. From the X-ray standpoint, improvement or its lack depends on the type of bony involvement; the proliferative type with its new bone formations will show little or no changes in the X-ray picture even over a period of years. Those cases wherein the lesions are of a destructive nature, the X-ray follow-up will show the deposition of new and healthy looking bone in the diseased areas.

As in other types of late syphilis, the effect of treatment is better measured by clinical rather than by serologic standards. If the patient's le-

sions heal, and if he remains well over an indefinite period of time, with no evidence of clinical progression or relapse of syphilitic lesions, the outcome is satisfactory regardless of whether sero-reversal is or is not secured.

Treatment of Ocular Syphilis

The proper management of ocular syphilis concerns equally the ophthalmologist and the syphilologist. Preservation of the vital function of vision and treatment of the systemic infection, syphilis, of which the ocular lesion is but a single manifestation is the chief goal.

That arsphenamine and its immediate derivatives have no deleterious effect on any of the structures of the eye has been shown by many observers. However, tryparsamide is of no value in the exudative and inflammatory lesions involving the external coat of the eye. Its only field of usefulness is in neurosyphilis. In the treatment of ocular syphilis, it should not be used when there is involvement of the optic nerve or the retina. Moore and Woods have shown that the incidence of symptoms of intolerance following its use is much greater in patients with pre-existing visual damage; and under these circumstances there is grave risk of toxic amblyopia and permanent blindness.

Local ophthalmologic treatment should be advised by the ophthalmologist. The anti-syphilitic treatment of iritis accompanying early or relapsing secondary syphilis is the same as that of early syphilis. Treatment should begin with an arsenical drug; there is no point in preliminary heavy metal treatment to avoid therapeutic shock, which is not important in iritis. The ocular lesion usually heals promptly without residual damage. Treatment must be continuously prolonged for a full year after serologic tests have become negative.

Late iritis should be managed the same as late syphilis. The radical "cure" is no longer the goal; treatment may be less intense. However, again the presence of complicating cardiovascular or neurosyphilis may modify the plan of treatment completely.

Syphilitic primary atrophy, so frequently associated with tabes dorsalis, is, in most instances, identical with that of tabes. Secondary syphilitic atrophy is the end result of neuro-retinitis or optic neuritis or is associated with extensive inflammatory lesions of choroid and retina. The course of untreated syphilitic optic atrophy invariably leads to complete blindness. It may begin unilaterally, but the second eye always becomes involved. When a patient is once completely blind and the fibers of the optic nerve have completely

degenerated, it is obvious that vision cannot be restored by any form of treatment. Early diagnosis and the prompt institution of treatment are the important factors in preserving vision. Delay and procrastination are fatal to the preservation of vision.

The routine antisyphilitic treatment plan as recommended in late latency or late syphilis introduces the fatal element of delay. During the time consumed by the lengthy routine further degeneration of the diseased nerve will occur, consequently, a much more rapid and intensive plan is recommended, as follows:

1. Check visual fields frequently (2-3 months) for progressive failure or improvements.
2. Complete physical examination.
3. Administer fever treatment (malaria). (a) Inject intravenously 8 cc. of quartan or tertian malarial blood (preferable after chill). (b) Allow 4-12 chills and 40 hours of temperature 104 degrees and above, then terminate malaria.
4. Do not give arsenicals or bismuth.
5. The late latent plan of treatment should be instituted after malaria is terminated.

Interstitial keratitis is a common late lesion often found in congenital syphilitics. The success of antisyphilitic treatment again depends largely on early diagnosis and prompt continuous treatment.

The plan of treatment should include alternating courses of neoarsphenamine and bismuth subsalicylate, given weekly. Treatment should be continuous, without rest until a minimum of 30 injections of an arsenical preparation and 40-60 bismuth are given. Treatment should be continued for a period of 2 years, regardless of serologic progress.

Treatment of Cardiovascular Syphilis

Excepting only neurosyphilis, cardiovascular syphilis the most frequent basic cause of death from acquired syphilis. Life expectancy may be greatly lengthened if it is recognized and adequately treated in the stage of uncomplicated aortitis.

In considering methods and results of treatment, it is essential clearly to identify the type of cardiovascular syphilis. The prognosis is vastly better and the choice of treatment procedures different in patients in whom aneurysmal sacculations, aortic insufficiency or pronounced myocardial damage have already appeared. The average duration of life in even the most severe cardiac involvements through adequate treatment will be lengthened from 4-20 years.

It is no longer justifiable to withhold specific

treatment from patients with cardiovascular syphilis, even when the situation seems hopeless. Treatment can be adjusted so as to do no harm; and miraculous recoveries may sometimes be secured.

The principles of treatment of cardiovascular syphilis may be briefly summed up as follows:

General medical care:

1. Rest.
2. Restriction of physical activity.
3. Digitalis when needed.
4. Nitroglycerine and the obromine derivatives for pain.

Specific treatment:

1. Avoid immediate grave treatment reactions. Do not use arsphenamine in any dosage.
2. Avoid therapeutic shock—the Herxheimer reaction. Prepare the patient with 4-8 weeks of bismuth and iodides therapy.
3. Continue preparatory heavy metal treatment for 8-12 weeks before attempting arsenicals.
4. Avoid even minor treatment reactions if possible. Use mapharsen, neoarsphenamine or bismarsen in very small doses and gradually increase the dosage.
5. Make treatment prolonged—minimum 2 years—and continuous.

Neurosyphilis

For the proper treatment of a patient who has syphilis, it is mandatory at some time or other during the course of treatment that his spinal fluid be examined. Should the spinal fluid be negative at the completion of intensive treatment or after six months of routine treatment, there is slight chance that it will ever be positive.

Again, the early diagnosis of central nervous syphilis as well as early syphilis, followed immediately by adequate treatment is the keynote for "cure," or prevention of further damage. This means that neurosyphilis must be discovered early or during the asymptomatic stage (usually the first ten to twenty years after infection).

There are three significant changes in the spinal fluid which are pathogenomonic. These are (1) a positive complement fixation (Wassermann or Kolmer) or a positive flocculation (Kline) test which manifests the presence of reagin, (2) an increased cell count, and (3) increased globulin content or total protein which indicate that meningeal initiation is present. When the cell count is abnormal (above 10 per cu. mm. fluid) some type of meningeal initiation is indicated. The intensity of meningeal initiation is indicated by the number of cells present. The cell count should be

made immediately after the spinal fluid is obtained. One may expect to find any number of cells up to 100 in late meningovascular syphilis and in tabes dorsalis and up to 200 cells in general paresis. The cell count in asymptomatic neurosyphilis will range from 0-200. A cell count of 150 or above certainly indicates the presence of syphilitic meningitis, especially with a positive spinal fluid (Wassermann) and makes mandatory the institution of immediate intensive treatment.

The globulin content or the total protein is, along with the cell count, an important adjunct in the interpretation of abnormal spinal fluid findings in evaluating meningeal initiation. The globulin content can be easily determined by adding spinal fluid to an equal amount of saturated ammonium sulfate and grading the turbidity produced as 1 plus, 2 plus, 3 plus and 4 plus. Should the spinal fluid be normal, no turbidity will be produced. The Pandy test is a test for total protein. The quantitative determination for total protein is more informative than the qualitative test. Normal spinal fluid may contain from 15-35 mg. per cent total protein; higher percentages are likely to be abnormal and significant.

The colloid tests are the mastic, gold and benzoin. All the tests are similar and non-specific, as to actual diagnostic value they are over-exaggerated. The type of curve obtained depends largely upon the concentration of albumin and globulin in the fluid. Should the fluid contain a larger amount of globulin as compared to albumin, it will give a paretic curve; if it contains large amounts of both albumin and globulin, the curve will be of a meningitic type. Any type of curve may appear in any type of central nervous system involvement, syphilitic or otherwise. Thus the idea that the colloidal test zone curves are helpful in distinguishing between paresis, tabes, unclassified neurosyphilis or infectious meningitis is in error. The colloidal tests may be helpful to the physician in evaluating the spinal fluid findings if he considers more thoroughly the spinal fluid Wassermann, cell count and the total protein or globulin.

Routine treatment of asymptomatic neurosyphilis consists of alternating courses of weekly injections of trivalent arsenic (mapharsen, neoarsphenamine, phenarsine hydrochloride, etc.), and bismuth for a total of 40 arsenicals and 40 heavy metals. When minimal spinal fluid changes and a negative Wassermann test are obtained, a prolongation of six months to a year of the routine treatment will suffice.

Should the spinal fluid present moderate or intermediate abnormalities, including a positive Wassermann test, an intensified treatment routine should be instituted for six months to a year. The spinal fluid should be examined every 4-6 months. Should the spinal fluid findings fail to show improvement, either fever or tryparsamide therapy should be instituted, and followed by routine therapy. Such patients should be treated for two or three years.

Should the spinal fluid present marked (paretic) changes, fever therapy followed by prolonged routine treatment should be instituted immediately. The total period of treatment should be at least three years.

The early adequate treatment of asymptomatic neurosyphilis should again be emphasized as the prophylaxis against the development of symptomatic neurosyphilis. The greater the spinal fluid abnormalities, the greater is the likelihood that, without proper treatment, paresis or tabes will develop with the accompanying destructive lesions of the brain tissue and the spinal cord. Such permanent damage cannot be repaired through any type of treatment; the only hope then is to possibly prevent further progression of the destructive changes.

Fever therapy as referred to is:

1. Malaria fever (see plan outlined in primary optic atrophy) and
2. Artificially induced fever through (cabinet) mechanical means.

The plan of artificially induced fever in a combined chemothermic or intensive plan of therapy is as follows:

1. Complete physical examination which should include cardiac reserve determination, liver functions, etc.
2. Adequate fever should include a total of 40 hours of fever maintained between 105-106 degrees.
3. Each treatment should be of 5 hours two times weekly for 4 weeks or a total of 8 fever (rides) treatments.
4. During the period of fever therapy the patient should receive weekly two doses .06 gm. mapharsen and .20 gm. bismuth.
5. After completion of the 8-week chemothermic therapy, treatment should be continued under the plan of treatment as outlined for late latent syphilis or weekly injections of tryparsamide for 6 months, then recheck the spinal fluid.

Tryparsamide should never be used unless adequate facilities for routine visual field examinations are available.

If this review or summary supplies an aid or helpful answer, although it be qualified as incomplete, and brief, to the frequent question of the physician as to how syphilis should be managed and treated, the effort required in reviewing the literature will have served its purpose.

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COMMUNIQUE

Jan. 2, 1945.

To the Editor:

Thanks for Random Thots, much appreciated. Also enjoy communiques in The Journal. Frank Burton, Jack Ellis and Jett Scott are really holding up Hot Springs' end of the deal. Great fellows—all of them.

I am now chief of surgery at Shaw Field so wished you to have my new address.

Happy New Year.

Berry Bowman, Capt., M. C.,
Station Hospital,
Shaw Field, S. C.



MODERN CONCEPTS OF CARDIO-VASCULAR DISEASE

Committee on the Heart, Arkansas Medical Society
C. T. Chamberlain, M. D., Chairman, Fort Smith

The Committee feels that it is worthwhile to evaluate from time to time the status of our knowledge of arterial hypertension in light of recent advances with reference to investigative studies and the possibility of their clinical application. There follows part I of a summary of essential hypertension by E. M. Landis, and published as No. 8 in Volume XII of Cardiovascular Concepts. Part II will follow later.

"Hypertension, as it occurs in man, is not a disease entity, nor even a uniform syndrome with consistent symptomatology and course. On the contrary, elevation of arterial pressure is merely a clinical sign which occurs in a large number of diseases and may be produced by one of several mechanisms. Thus when hypertension is found the clinician is faced immediately with the important problem of discovering as soon as possible by careful history, physical examination and intensive special study whether the elevated arterial pressure (a) is merely a secondary result of another and underlying disease, (b) is due to a remediable renal lesion or (c) is truly a hypertension of unknown etiology.

"Essential hypertension as a diagnosis refers to an abnormally high systolic and diastolic arterial pressure occurring in individuals who do not have inflammatory kidney disease, urinary tract obstruction or other disorders which are known to result in elevation of the blood pressure. It is really a diagnosis arrived at by exclusion of other conditions.

"Pathogenesis: Certain rules apply to the pathogenesis of all types of hypertension, whatever their cause or course. An elevation of arterial blood pressure might conceivably be due to (1) increased blood volume, (2) increased viscosity of the blood, (3) increased cardiac output, (4) increased peripheral resistance by arteriolar constriction or (5) any combination of these four factors. In addition, cardiac output and peripheral resistance are controlled partly by the sympathetic nervous system and partly by circulating hormones, so that changes in these two factors are susceptible of still further analysis. Essential hypertension has been studied more completely in this respect than have other types of hypertension.

"Cardiac output, blood volume and blood viscosity having been found normal, it became ob-

vious that increased peripheral resistance must be the important abnormality. Because physiologists, beginning with Ludwig, had demonstrated that constriction of the splanchnic vessels can elevate systemic blood pressure conspicuously, the favorite earlier hypothesis held that the major abnormality in the hypertensive individual consisted of an increase in peripheral resistance due to increased tone of the splanchnic arterioles particularly.

"However, if vasoconstriction were limited to the splanchnic vessels it would be expected that the resulting hypertension should increase the flow of blood to other regions such as skin and muscle where, according to this hypothesis, arteriolar tone is still normal. Yet it was found that blood flow in the extremities and, by indirect methods, in brain tissue is generally within normal limits. The figures, with few exceptions, offer little or no evidence for selective and excessive constriction in the splanchnic area, but suggest rather a slight and widespread increase of arteriolar tone throughout the whole vascular system.

"Despite this increase in basic tone the arterioles still respond approximately normally to local heat, local cold, metabolites, epinephrine, pituitrin, histamine, tyramine, body warming and body chilling. Some sensory stimuli, e. g. noise, pinching and deep breathing, produce in hypertensive individuals a vasoconstriction which is qualitatively and quantitatively similar to that occurring in normal subjects.

"These observations provide a rational explanation for the insidious onset of hypertension in most instances, and for the frequency with which it is discovered by accident. These patients do not suffer from diminished blood flow, nor is there gross evidence of significant ischemia of vital organs until structural changes develop in their arteries or arterioles. Despite well-established hypertension we frequently find that the kidneys are performing their excretory functions normally as measured by rough clinical methods such as a concentration test, phenolsulphonphthalein elimination, or urea clearance. With more refined tests by inulin and diodrast clearances, Smith and his co-workers have concluded that the efferent arterioles in the kidneys are constricted, and that renal blood flow is reduced, but that the volume of glomerular filtrate is nevertheless maintained at its usual level because the blood pressure, and therefore the filtration pressure, in the glomerular capillaries is increased. The results indicate that, of the various tissues studied so far in hypertension, kidney tissue is more likely than others to have an abnormally low flow and that

renal blood flow diminishes prior to, rather than with, the destruction of the renal parenchyma. In the extremities, on the contrary, arteriolar tone and blood pressure are increased more nearly in proportion so that blood flow remains approximately normal until cardiac failure or vascular sclerosis supervenes.

"This generalized increase in arteriolar tone throughout the body might be either neurogenic or humoral in origin. The evidence obtained in experimental hypertension produced in animals by Goldblatt is overwhelmingly against the existence of overactivity of the sympathetic nervous system. Total sympathectomy neither prevents the development of hypertension in animals nor reduces hypertension induced previously. In essential hypertension of man the evidence is less clear. When sympathetic vasoconstrictor impulses to the extremities of hypertensive and normal individuals are blocked by local anesthesia, or caused to disappear by reflex vasodilatation, blood flow increases about equally in both, indicating that the sympathetic nervous system is not overactive. Yet in selected patients sympathectomies have been followed by lowering of blood pressure and also by regression of certain symptoms and signs of hypertension.

"The evidence for a humoral mechanism is more varied and suggestive but still not complete. Transplantation of an 'ischemic' kidney into the neck of a nephrectomized dog elevates the blood pressure, while complete ligation or removal of an 'ischemic' kidney from a hypertensive dog reduces blood pressure. In man, hypertension has been reduced by the surgical removal of a single kidney injured by pyelonephritis, hydronephrosis, or congenital anomaly usually affecting the circulation. A diseased kidney may therefore produce in man a 'renal hypertension' analogous to that which Goldblatt produces in animals by reducing the lumen of the renal artery.

"The search for a pressor substance in the blood of patients with hypertension has been intensive at intervals for many decades. Epinephrine, pituitrin, tyramine and guanidine have all been referred to as the responsible agents at various times in the past but their concentrations in the circulating blood have not been consistently elevated in hypertension and sporadic studies claiming increased vascular sensitivity to certain of these compounds have not been confirmed. None of them produce the generalized and accurately balanced increase of blood pressure and peripheral resistance which is required if peripheral blood flow is to remain approxi-

mately normal despite hypertension. These substances produce a profound peripheral vasoconstriction and reduce blood flow in the skin, while hypertensive patients and animals retain a normal cutaneous circulation.

"In 1898 Tigerstedt and V. Bergmann observed that saline extracts of kidney tissue, while sometimes toxic, usually produced a slowly developing rise of blood pressure persisting for 30 to 45 minutes after injection intravenously. In striking contrast to most other pressor substances the protein-like 'renin' in these purified kidney extracts elevates blood pressure in experimental animals without reducing peripheral blood flow, matching to that extent the circulatory condition characteristic of clinical hypertension. The rise in blood pressure is temporary, however, and repeated injection leads to diminishing effect (tachyphylaxis). Page and Houssay found independently that 'renin' is not itself pressor but on combination with a pseudoglobulin in blood plasma (renin activator, Page; hypertensin precursor or hypertensinogen, Houssay) produces a dialyzable constrictor substance (angiotonin, Page; hypertensin, Houssay), which is directly pressor when injected into animals and man. Recent evidence suggests also that from normal kidney tissue can be obtained a substance or substances of unknown composition and stability which destroy angiotonin and hypertensin.

"In the past 40 years many workers have claimed that it is possible under certain circumstances to demonstrate in the blood plasma of hypertensive patients or animals unique constrictor activity whereas control plasma injected into the same test preparations is inert. It must be confessed, however, that while many methods have been suggested none has so far proved generally dependable in clinical work, and in none has there been proved any consistently quantitative relation between the height of blood pressure and the intensity of constriction induced in the assay preparation. Transfusions of blood from hypertensive donors into normal subjects have yielded equivocal results. Various prepared extracts from kidneys of hypertensive animals and patients are not uniformly more pressor than similar extracts of normal kidneys, though average results sometimes suggest a greater renin content.

"Another hypothesis suggests that the pressor material responsible for hypertension is one or more of the pressor amines, which might be released when ischemia interferes with the action of enzymes such as decarboxylase and particularly amine oxidase which have been found in

kidney tissue. These enzymes, acting for example on di-hydroxyphenylalanine in the presence of oxygen, produce di-hydroxyphenylacetic acid, an inert substance, whereas in the absence of oxygen hydroxytyramine, a pressor substance, appears instead. Again, demonstration of amines in the blood of hypertensive patients has been claimed, but not so far verified by wide testing. It must also be recalled that while tyramine elevates blood pressure it does not duplicate the hypertensive state so exactly as renin. The renin and amine hypotheses are both of theoretical interest because they (2) attempt to explain the 'humoral' factor in hypertension and (b) form the basis of two efforts to devise a 'specific' treatment of hypertension, both being still in the experimental stage.

"Despite the evidence in favor of the humoral concept and despite the inability to demonstrate abnormal activity of the autonomic nervous system, it must be emphasized that vasoconstriction of the neurogenic type is superimposed periodically upon the high basal arteriolar tone characteristic of hypertension, just as is the case in the transient physiological elevations of blood pressure in normal individuals. Clinically it is agreed that significant reduction of pressure occurs in many hypertensive patients during mental and physical rest. Blood pressure can be reduced abruptly, though not quite to normal levels, by compression of the carotid sinus so that the moderator mechanism is apparently intact, though overpowered by a more potent agent. The frequent association of essential hypertension with continued nervous tension, emotional stress and anxiety, indicates also that even though the fundamental abnormality be humoral in origin, the sympathetic nervous system can still accentuate the grade of hypertension and accelerate its advances.

"Moreover, constitutional susceptibility and heredity seem to play a significant role in many instances. A history of hypertension occurring early in life in a patient's parents or siblings is found in some cases of the malignant form of essential hypertension. The children of hypertensive patients often react with an exaggerated rise of pressure when one hand is immersed in cold water. These 'hyper-reactors' appear to be more likely to develop hypertension in later life than are those who react normally. Given an equal amount of organic renal disease, as in polycystic kidney disease or pyelonephritis, hypertension appears in some individuals and not in others. These variations may be due to unrecognized differences in the details of structural

damage, to an hereditary defect or to early environmental changes but in any case illustrate the highly variable response of the vascular system to types and grades of renal pathology which seem similar by present methods of examination.

"Pathology: In a few well-studied cases persistent hypertension has existed for years, and, death having been caused by another condition, autopsy has revealed no significant pathology of the renal arterioles. The nearest approach to a comprehensive *in vivo* study of this type in man is a very recent one by Castleman and Smithwick. In renal biopsies from 100 patients subjected to sympathectomy for treatment of hypertension it was found that in 53 the organic renal vascular disease was so slight that it seemed unlikely that this cause alone could have reduced renal blood flow sufficiently to make this one factor solely responsible for the hypertension. If these biopsies represent accurately the state of the entire vascular bed of both kidneys, it seems likely that the degenerative lesions seen after death are secondary to hypertension and not its cause. Attention must once more then be focused upon simple arteriolar spasm as the initial inciting agent in man, which may begin the same cycle produced by clamping the renal artery which Goldblatt has used so successfully to produce hypertension in animals.

"After death from long-continued effects of chronic essential hypertension, however, organic vascular disease in the kidneys is found in practically every instance (Moritz and Oldt). In benign nephrosclerosis death from renal insufficiency and uremia is rare, and pathologists find less striking renal changes. Patients with the malignant form of essential hypertension are much more apt to die in uremia and then subcapsular hemorrhages, necrosis of afferent arterioles and gross destruction of glomeruli are almost always found at autopsy. The earlier tendency to regard benign and malignant arteriolar nephrosclerosis as separate diseases is less tenable since Goldblatt has shown experimentally that animals will develop a benign or a malignant form of hypertension and corresponding arteriolar disease depending upon whether renal ischemia and renal insufficiency are mild or severe respectively. Clinicians are therefore justified in speaking of the benign phase, or malignant phase, of essential hypertension particularly since occasional patients will exhibit fairly clear transitions from a benign to a malignant course; and at autopsy the pathologist may find organic changes characteristic of both conditions.

"The relative importance of slight but definite

unilateral abnormalities of the renal pelves, vessels or ureters has been explored during life in hypertensive patients by urography, both intravenous and retrograde. In autopsies sclerosis and partial thrombosis of the renal arteries are found rather frequently. Even though true 'renal' hypertension, in the sense of being curable by unilateral nephrectomy, is relatively rare, it still occurs frequently enough to make it obligatory to exclude the possibility of gross unilateral disease in every case of hypertension not otherwise explained.

"Finally, any hypertension, whatever its cause, increases the work of the heart, induces hypertrophy and predisposes to failure. The arterioles and arteries become sclerotic and subject to thrombosis or hemorrhage. The vessels of the spleen, pancreas, coronary system and brain all may be involved to different degrees. The varying symptomatology of hypertension in its later stages reflects the focal and unequal distribution of these sclerotic changes."

Acknowledgment is hereby made of permission by the American Heart Association to publish the above.

COMMUNIQUE

November 11, 1944.

To the Editor:

*** I have moved and now occupy where the Japs were up until recently. We use their trenches which are too shallow for us. We use their barracks which are dug in, too. It is really cold on this mountain and we have no form of heat yet which means you go to bed early and pile on everything you have and sleep in your long drawers. Just heard we still have our same president again.

Sincerely,
H. A. Causey, Capt., M.C.

COMMUNIQUE

December 11, 1944.

To the Editor:

Thank you for "Random Thots." I received it today after it made all previous stops following me around.

I have been assigned at the address below but cannot say how long I will be there. As I move I'll keep you informed so that my mail will catch up with me.

Yours,
Robert W. Boyle, Capt., M. C.
Regional Hospital No. 3,
Fort Bragg, North Carolina.

COMMUNIQUE

December 14, 1944.

To the Editor:

Have been regularly receiving The Journal and keeping up with activities back in Arkansas. This letter will bring you up to date on me.

Several month ago I received my majority and just recently was transferred to this headquarters as a member of the Surgeon's Staff, Hq. A. T. C.

Enjoy reading about the activities of the other members in the service and hope I shall continue to receive The Journal.

Sincerely,
Hugh W. Savage, Major, M. C.

COMMUNIQUE

January 1, 1945.

To the Editor:

To start the New Year right, I am sending you my correct address though the old one which you have been using was successful in reaching me. I am now stationed in the Office of the Deputy Theater Surgeon with title of Theater Epidemiologist. Whereas I used to stamp out diseases in Arkansas while serving as a county health officer in Miller and Mississippi counties, I have a somewhat similar job with the Army in **. I enjoy my assignment and always receive a pickup in morale when your letter comes through.

Sincerely,
Kirk T. Mosley, Maj., M. C.

COMMUNIQUE

January 1, 1945

To the Editor:

It looks like this effort is the result of a New Year's Resolution but it really isn't, nor is it the result of self-discipline for last night. I only want to wish you a Happy New Year.

I had a visit with Harvey Shipp the other day and we had planned on "throwing a good one" last night but it couldn't be arranged.

I have been chief of surgery for the past three months. The reason you haven't received comments on your sly piece of wit, "What Our Naval Colleagues Are Reading," is that we didn't receive the November issue of The Journal until last week. It shows that the X-ray men are getting up in the world and carrying over into official communiques that technique of their usual reports in making simple things look complicated. Thanks for the news.

Yours,
Fred H. Krock, Comdr., U. S. N.

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(Appointments expire with the annual session of the year indicated.)

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*In military service.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

TUBERCULOSIS among older people remains one of the stubborn pockets of resistance in the general campaign aimed at the eradication of the disease. For the most part we must rely upon the general practitioner to carry out this phase of the struggle, for the individuals concerned are usually among his patients and outside the range of the present "mass" control measures.

TUBERCULOSIS IN ELDERLY PEOPLE

The importance of tuberculosis in elderly people, especially pulmonary tuberculosis, has been generally underestimated. One reason for this is that few of us have any conception of the number of older people among us. There are in the United States nearly four thousand persons over 100 years old; over 87 thousand who are past 90; more than one million who are over 80; more than five million over 70; and 13.5 million over 60. These, with 13 million in their fifties, makes a total of over 26.5 million persons over 50, more than 20 per cent of the whole population.

The U. S. Census figures for 1870 showed only about 11 per cent of the population over 50 at that time. A reduction in mortality from infectious disease, increased application of sanitary science, better housing and nutrition are all contributing to the longer life of the present day. How permanent the present large percentage of older people in the population will be, we cannot tell. Continued wars followed by widespread epidemics, may again reduce life expectancy to that of the middle ages.

Now, however, when about one-fifth of our population is elderly, it is important that we know how much of it harbors tuberculosis, and how much of a menace to the community this represents. Is tuberculosis in the later decades of life increasing?

Figures from the U. S. Census Bureau show that the mortality rates from tuberculosis in the United States in 1940 were much higher in the later decades of life than among young people. The highest rate in 1940 at any age period, that of males between 55 and 65, was 110 per 100,000. In 1900 the highest rate for males, 362 per 100,000, was in the age period, 35 to 39.

The death rate from tuberculosis is still, relatively high in persons over 50, and since this group forms about 20 per cent of the population, there are many elderly tuberculous persons in the country. Using the very conservative factor of five active cases for every death, the active cases, many of which are spreading infection, may be estimated as at least 100,000. Not all of these cases are in sanatoria.

Pathology

There has been a great deal of controversy regarding the seriousness of tuberculosis in old people. Some have considered it relatively benign, while others have thought it rapidly progressive. In one report of a series of 142 cases over 55 years of age admitted to a sanatorium, many of the patients had active tuberculosis with positive sputum for periods of from 10 to 40 years. The number of tubercle bacilli eliminated by sputum-positive cases which remain positive for periods as long as 10, 20, 30 or 40 years, can only be faintly realized or comprehended, in this respect being comparable only to national expenditures for war and other purposes.

The patients in sanatoria are for the most part those with active or progressive lesions. Probably a large proportion of the fibrotic cases with few symptoms are at home. This circumstance makes it difficult to determine the typical characteristics of pulmonary tuberculosis as it affects elderly people.

Aging tissues are said to be less susceptible to inflammatory processes than growing ones, and tend to develop fibrous change. Obliteration of lymphatic channels and involutional changes take place which may render the body resistant to the spread of tuberculosis. On the other hand there is probably concomitant atrophy, decalcification

and dehydration. A few individuals may reach old age without previous infection and develop primary tuberculosis, not always distinguishable clinically from reinfection tuberculosis.

Many elderly persons who have definitely recognizable tuberculous lesions with positive sputum have become somewhat immune to the toxic effects of their disease, and make up a highly infectious class. In this group are included the so-called 'good chronics' with positive sputum who do not consider themselves ill. Some of them care for young children or are otherwise in close contact with susceptible persons.

The course of events in any individual case is dependent not only on exposure to fresh infection or on the reactivation of old quiescent foci, but also on the endowment of the individual with more or less resistant tissues. Although tuberculosis may only become manifest and troublesome in later life, its origin usually is to be sought in an earlier period.

Differential Diagnosis

While tuberculosis is relatively common in later life, its detection is frequently difficult. Diseases likely to cause confusion are frequently met. Included among them are cancer, cardiovascular disease, chronic bronchitis, emphysema, bronchiectasis, asthma and silicosis. If the sputum does not contain tubercle bacilli, the differentiation becomes increasingly difficult. Cough, weakness, loss of weight, hemoptysis and other symptoms found in tuberculosis may be present in other conditions with consequent difficulty in differential diagnosis.

Many cases of tuberculosis in older people are not detected because few of them have had chest X-rays. Most of the surveys have been among children and young people who are much more easily persuaded to cooperate. It has been difficult to secure the consent of older people for examination. They pay less attention than young people to declining health, which they feel is to some extent inevitable. Their tired feeling they consider a normal accompaniment of old age. They do not like to change their environment and are fearful lest there may have to be radical alterations in their way of living. Inertia and dread of loss of security make them hesitate.

Methods of search for unsuspected cases of tuberculosis, however, are changing. The X-ray, our most valuable resource for this purpose, is being used more freely since it is becoming less expensive. An X-ray of the chest will soon be part of the routine examination of all patients seen

by physicians in their offices, just as it is now becoming a part of up-to-date clinic practice.

Treatment

The treatment of tuberculosis in old people is in many respects the same as it is for those in early life. Rest of the inflamed area is the keynote and will probably be necessary even if some day some form of chemotherapy is found. Certain difficulties in the rest treatment of elderly patients are apparent. Complete immobilization is not well borne by the aged and mechanical measures to secure lung rest are less applicable for them. Symptomatic treatment and good nursing may bring good results where mechanical adjuncts to bed rest are not advisable. Exceptional cases will doubtless have to remain at home. The physician should, however, not accede to such a plan without a full realization of the risks involved, and the possibility of infecting an entire family and a new generation.

The entire population needs and deserves good medical supervision. Persons with arrested tuberculosis, in order that they may be kept from reactivating their lesions and becoming spreaders of tubercle bacilli need more than the average medical attention. Older persons in this category will require as much consideration and follow-up as younger patients.

(Tuberculosis in Elderly People, A. T. Laird, M. D., *The Journal-Lancet*, June, 1944.)

COMMUNIQUE

Dec. 11, 1944.

Dr. Geo. B. Fletcher,
Hot Springs National Park,
Arkansas,
Dear Doctor Fletcher:

Many thanks for the monthly letter, I always look forward to receiving them but unfortunately they do not always reach me, due, maybe, to frequent changes that have occurred in my address. Hence, I am sending this letter with my correct address.

It is swell to read in your letter about what the army is doing for the boys in Hot Springs by placing them in nice hotels and providing good food and entertainment. I'm sure the fellows really appreciate this fine treatment.

Thanks again for the letters and cheerio!

R. L. Turnbow, Capt., M. C.

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EDITORIAL

REHABILITATION

With a realization of the occupational dislocation of many thousands of persons as a result of the present war, Congress has enacted the Vocational Rehabilitation Law for physically handicapped civilians. This law is designed to be administered through the Office of Vocational Rehabilitation of the Federal Security Agency at the Federal level and by the Division of Vocational Rehabilitation of the Department of Education at the state level.

The Federal government now assumes the entire cost of administration of the state program and will make grants to the states for actual requirements. The Federal government will also assume half the cost of medical examinations, surgical and other treatment, hospitalization, prosthetic appliances, transportation, occupational tools and licenses, rehabilitation training and maintenance. In the case of war-disabled civilians (members of citizens defense corps, aircraft warning service, civil air patrol and the merchant marine), the entire cost of these services will be assumed by the Federal government.

Sole responsibility for the administration, su-

pervision and control of the program rests with the State Boards of Vocational Education. A complete state plan of vocational rehabilitation for a disabled individual is composed of nine integral factors, all of which operate to restore the individual's working and earning capacities. To meet the total needs of handicapped persons, a well-rounded program includes the following services. Except where indicated, Federal reimbursement is not conditioned on the establishment of financial need.

1. Location of persons in need of rehabilitation. The cooperation of all private and public agencies of health, welfare, etc., is necessary in locating disabled persons and in carrying out the steps involved in the successful completion of their rehabilitation. Such individuals may have some assurance that a life of dependency may not be theirs and they may look to the future with hope.

2. Physical and vocational diagnoses. A medical diagnosis is required to establish the general health and medical history of the individual, including organic and functional conditions. This will indicate the type and extent of medical or surgical care needed, and must be taken into consideration together with the vocational diagnosis. This latter consists of an analysis of the individual's intelligence, education, experience, interests and aptitudes, as well as environmental and personality factors.

3. Vocational guidance. Most handicapped individuals are in need of guidance in selecting suitable fields of work.

4. Medical, surgical and prosthetic services. The type of training and work tolerance must be determined in the individual case by the physician working jointly with the guidance and training specialist. With the exception of war-disabled civilians and civil employees of the United States, disabled in the performance of their duty, the inability of the individual to pay for the needed medical services must be established before Federal requirement for the cost of these services is made.

5. Physical and occupational therapy and psychiatric services. Therapeutic services must be closely integrated with other preparatory services. Individuals in need of psychiatric care should receive these services in addition to other care. Where such therapeutic and psychiatric services are parts of the medical and surgical treatments being rendered, inability to pay for these services must be established before Federal reimbursement can be made.

6. Vocational training. Those disabled per-

sons whose impairments have incapacitated them for their normal occupations, or who have never had vocational experience, or whose skills have become obsolete due to changing industrial needs, require vocational training. Specific training programs will have to be geared to the needs of disabled individuals as well as to the labor needs of the community.

7. Financial assistance. Lack of financial aid for persons undergoing training may jeopardize an otherwise promising rehabilitation plan. However, Federal reimbursement for the cost of maintenance during training is conditional on the establishment of need in all cases.

8. Placement in employment. Upon completion of preparation, the individual must be assisted in securing employment in accordance with his physical condition, qualifications and temperament.

9. Follow-up on performance in employment. Follow-up is needed to determine whether the handicapped worker was properly placed. Adjustments may be found necessary; medical follow-up may be needed; a prosthetic appliance may need adjustment; the individual may need supplementary training; or he may need some other special assistance.

Two objectives stand out in the program. First, disabled manpower must be salvaged. Second, with thousands of disabled persons seeking employment in the post-war period, proper facilities should be available to assure them employment. In the accomplishment of these objectives, full use will be made of existing voluntary and governmental agencies of the community. The medical profession has a particularly large and important part in the successful operation of the plan.

EDITORIAL COMMENT

PROPOSED AMENDMENT TO THE BY-LAWS

The following amendment to the By-Laws of the Society was proposed at the 1944 annual session and will be acted upon at the 1945 annual session:

Resolved, that the By-Laws of the Arkansas Medical Society be amended substituting the following:

"An active member who shall have attained his eightieth year and shall have been a member of his county medical society in Arkansas or elsewhere in the United States continuously since beginning the practice of medicine, or who for fifty years shall have been continuously a mem-

ber of his county medical society in Arkansas or elsewhere in the United States, shall, upon establishing the above facts to the satisfaction of his county society, and upon the recommendation of such society, be granted the status of a life member. Such member shall enjoy full membership privileges and shall be exempt from the payment of further dues or assessments. An active member in good standing in his county society may, upon the recommendation of such society, be granted affiliate membership with full voting and other privileges where one or more of the following conditions exists: retirement from practice; physical or other disability of a character preventing the practice of medicine; a serious and prolonged illness; or financial reverses.

"Affiliate membership shall be on an annual basis only and a member must be recommended each year for such special status by the secretary and president of his county medical society following a review and reassessment of his particular situation. An affiliate member shall enjoy full membership privileges and shall be exempt from the payment of dues and assessments during the year in which he is granted such status, and a certificate of membership shall be issued to him for such year."

HONORARY MEMBERSHIPS

The attention of county medical societies is called to the constitutional provisions affecting election of members to honorary membership in the state Society. To be nominated to the Council by a county medical society, the individual physician must have reached the age of 65 years, must have been a member of his county medical society for the preceding 15 consecutive years, must have been elected to honorary membership in his county medical society, must be a member in good standing at the time of nomination (1945 membership assessment paid) and must be nominated in writing to the Council. Members found qualified by the Council are nominated for election by the House of Delegates at the next annual session. Attention to these requirements by county medical societies will obviate misunderstandings and failure of selection of individuals who are properly qualified.

SCIENTIFIC EXHIBIT

The Committee on Scientific Exhibit asks that all members who may have scientific material for

exhibit at the 1945 annual session write the Committee Chairman, Dr. Jeff Banks, University of Arkansas School of Medicine, 1209 McAlmont Street, Little Rock. The scientific exhibit receives greater attention from the membership each year and it is hoped that there will be good cooperation from those members who have material in shape for presentation at the coming annual session.

RANDOM THOUGHTS OF THE SECRETARY

January 3rd. Whatever became of the "Commander-in-Chief" we heard so much about last October?

January 7th. The Council deliberates the many and varied problems of medicine, economics, government and the like far into the afternoon and we are happy over the enthusiasm with which the group steps forth to tackle the ever-increasing load of new activities and necessary decisions.

January 9th. The ladies take over the annual banquet session of the county medical society and, reviewing the glee and abandon with which Foltz, Eberle and Buckley handled the toastmaster's job in days gone by, we hand our orchids to the ladies in profusion for a party that was really a party. Through a female impersonator, the "dirt" was well spattered over the medicos present, but we shall not soon forget the astounding appearance of the impromptu quartet: Jones, Wolferman, Even and Col. Urmy, who, to say the least, displayed no musical talent on this occasion.

January 10th. Comes Amis from a dry-docked naval station returning to a post with which he began his career—recruiting, not to his complete enthusiasm. So all join to greet him in the social activities to which he inclines, an unaccustomed activity in large part for civilians.

January 17th. Whoever originated the saying, "a dog's life," never heard of airplane priorities, did he?

January 20th. Gathering with the obstetricians at Wolfermans' where comes Louie Rudolph of Chicago and the talk is of occiput posteriors, prolonged labors and contraction rings, talk decidedly of no interest to the ladies and only of passing scientific worthiness to us.

January 21st. At the Eberles' ranch this afternoon where this much gaiety, good food and fellowship and, as is our custom, we promote ill feelings between the Moulton and Eberle canines.

COMMUNIQUE

Dec. 23, 1944.

To the Editor:

Just wanted to drop you a line to let you know I have been receiving The Journal and Random Thots regularly, also Bill Stover's Christmas card. It really is nice to receive these.

See where brother-in-law Branch has had some experience in capturing Jerries. Sure would like to run into him sometime over here.

Only one change in the address—have received my railroad tracks and am now a captain.

Keep the news coming.

Regards,

Elbert H. Wilkes, Capt., M. C.

PROCEEDINGS OF SOCIETIES

Hempstead County Medical Society has elected the following officers: President, G. E. Cannon; vice-president, L. M. Lile; secretary-treasurer, Don Smith; delegate, J. E. Gentry, and alternate, H. G. Heller.

Johnson County Medical Society has elected the following officers: President, Earle H. Hunt; vice-president, Geo. L. Hardgraves; secretary-treasurer, G. R. Siegel; delegate, Earle H. Hunt, and alternate, Geo. L. Hardgraves.

The Craighead-Poinsett County Medical Society met in dinner session at Jonesboro January 4th for a paper by J. H. McCurry, Cash, "A Few Things I Saw and Learned in Fifty Years of Medicine." Talks were made by H. H. McAdams, P. W. Lutterloh, R. H. Willett, J. K. Jones, A. C. Modelvsky and L. H. McDaniel.

—J. H. McCurry, Secretary.

Randolph County Medical Society has elected the following officers: President, W. E. Hamil; vice-president, R. O. Smith; secretary-treasurer, M. A. Baltz; delegate, J. R. Loftis, and alternate, J. W. Brown.

The Pulaski County Medical Society was addressed January 8th by John F. Williams, Medical College of Virginia, on "An Introduction to Psychosomatic Medicine." Officers elected are: President, John N. Compton; vice-president, Hoyt R. Allen; secretary, L. L. Fatherree, and treasurer, R. M. Blakely.

—L. L. Fatherree, Secretary.

Little River County Medical Society has elected the following officers: President, E. W. Yates; vice-president, Norman W. Peacock; secretary-treasurer, C. A. Harding; delegate, Norman W. Peacock, and alternate, E. W. Yates.

Crawford County Medical Society has elected the following officers: President, C. J. Campbell; vice-president, S. D. Kirkland, and secretary-treasurer, S. C. Grant.

Searcy County Medical Society has elected the following officers: President, E. G. Fendley; vice-president, W. T. Moore; secretary-treasurer, J. O. Leslie, and delegate, H. J. Hall.

Lawrence County Medical Society was ad-

dressed at its December meeting by R. C. Shanlever, Jonesboro, on "Diagnosis of the Acute Abdomen," and by Joe Ledbetter, Jonesboro, on "Infectious Jaundice." Officers elected are: President, W. S. Kendall; vice-president, W. W. Hatcher; secretary-treasurer, Chas. D. Tibbels; delegate, J. C. Land, and censor, C. C. Townsend.

—Chas. D. Tibbels, Secretary.



OBITUARY

JUNIUS RUTH, age 59, of Rison, died January 6th en route to a hospital. Born near Warren, he graduated from the University of Nashville Medical Department in 1910 and had practiced in Bradley County since, 30 years in Rison. Surviving relatives are his wife, a daughter and two sons.

AUGUSTUS GARLAND LEE, age 70, Texarkana, died January 17th of a cerebral hemorrhage. Born at Lewisville, he graduated from Barnes Medical College in 1901 and had practiced in Texarkana for forty years. In addition to his membership in the Miller County Medical Society and the Arkansas Medical Society, he was a fellow of the American Medical Association. Surviving relatives are his wife and two sons.

MADELINE MULDOON MELSON, age 46, died at her home in Little Rock January 12th after an illness of several weeks. Born at Lone, California, she graduated in medicine from the University of California Medical School in 1924. Subsequently she became a member of the staff of the Mayo Clinic where she married Dr. O. C. Melson, who, with a son, survives her. Since 1925 she had practiced pediatrics in Little Rock, associated in practice with her husband. In addition to her membership in the Pulaski County Medical Society, the Arkansas Medical Society, and fellowship in the American Medical Association, she was a member of the American Academy of Pediatrics, being secretary of the Arkansas branch of this organization, a member of the Little Rock Country Club and of the Little Rock Garden Club.



PERSONALS AND NEWS ITEMS

Earle H. Hunt, Clarksville, was elected by the Council January 7th to serve the unexpired term of the late Clyde L. McNeil as Councilor from the Tenth District.

Dr. and Mrs. Paul L. Mahoney, Little Rock, celebrated their twenty-fifth wedding anniversary January 7th.

Lt. James C. Barnett, Heber Springs, M. C., U. S. N. R., is now on duty overseas.

Elbert H. Wilkes, Little Rock, now stationed overseas, has been promoted to captain.

Lt. Comdr. Gaston A. Hebert, Hot Springs, is now stationed overseas.

Capt. Harlan H. Hill, Little Rock, is now stationed overseas.

Capt. M. B. Bowman, Hot Springs National Park, is now on duty as chief of surgery at Station Hospital, Shaw Field, South Carolina.

Henry G. Hollenberg, Little Rock, now stationed at Bushness General Hospital, Brigham City, Utah, as chief of surgical service, has been promoted to colonel.

J. A. Summers, Little Rock, has been reappointed Pulaski County health officer.

A. K. Wayman, Little Rock, has been reappointed superintendent of the Pulaski County Hospital.

Married—On December 26th, at Little Rock, Robert Watson and Miss Pauline Lindsey Davis.

Lt. Col. W. W. Chamberlain, Hot Springs National Park, is now stationed at the 14th Regional Hospital, Camp Barkley, Texas.

"Surgical Disorders of the Chest, Diagnosis and Treatment," by J. K. Donaldson, Little Rock, now on duty as Major, Medical Corps, has been published by Lea and Febiger, Philadelphia.

Franklin County Medical Society has elected the following officers: President, W. C. Porter; Vice-President, E. W. Pillstrom; Secretary-Treasurer, W. H. Gibbons; Delegate, I. H. Jewell, and Alternate, W. H. Bollinger.

Louis K. Hundley, Little Rock, now stationed overseas, has been promoted to major.

I. R. Johnson has been elected vice-president of the Farmers Bank and Trust Company at Blytheville.

Maj. John M. Samuel, Little Rock, is now assigned to the Armored School, Fort Knox, Kentucky.

Capt. Gerald Blankfort, Little Rock, now on duty at the Army Air Forces Convalescent Hospital, Fort Logan, Colorado, as chief of medical services, has been elected to Fellowship in the American College of Physicians.

Charles W. Rasco, Jr., DeWitt, now stationed at Station Hospital, Army Air Field, Casper, Wyoming, has been promoted to captain.

Comdr. James W. Amis, Fort Smith, has been assigned to the Naval Recruiting Station, Little Rock.

Lt. Comdr. Thos. P. Foltz, Fort Smith, has been assigned to Naval Hospital, Norman, Oklahoma.

Jean Carl Gladden, Harrison, has been called to duty as Lieutenant, Medical Corps, Army of the United States, and assigned to Carlisle Barracks, Pennsylvania.

Capt. Earl J. Bieri, Hot Springs National Park, is now assigned to Headquarters, Biggs Field, El Paso, Texas.

Capt. John B. Elders, Walnut Ridge, is now assigned to the 541 Med. Collect. Company, Fort Riley, Kansas.

Nevada County Medical Society has elected the following officers: President, T. W. McDaniel, Boughton; vice-president, J. B. Hesterly, Prescott; secretary-treasurer, A. S. Buchanan; delegate, A. S. Buchanan, and alternate, J. B. Hesterly.

Cross County Medical Society has elected the following officers: President, A. F. Barr, Cherry Valley; secretary-treasurer, Thos. Wilson, Wynne; delegate, Thos. Wilson, and alternate, A. F. Barr.

Dr. and Mrs. W. C. Russwurm, Helena, celebrated their golden wedding anniversary on January 10th.

The Fifth Councilor District Medical Society has elected the following officers: J. P. Clemens, president; L. A. Longino, vice-president, and E. J. Munn, secretary-treasurer.

W. C. Riggins, Little Rock, recently discharged from military service, is taking postgraduate work at New York Polyclinic.

Dr. and Mrs. R. B. Robins, Camden, attended the inauguration ceremonies in Washington January 20th.

Maj. Hugh Mobley, Searcy, who has been in service in the Pacific area for nearly three years, recently visited home on leave.

C. P. Sisco has been elected a director of the First State Bank at Springdale.

Capt. James H. Moseley is now stationed overseas.

Maj. Hollace D. Fowler, Little Rock, is now stationed overseas.

The Arkansas State Board of Health has elected M. E. McCaskill, Little Rock, president; E. D. McKnight, Brinkley, vice-president, and T. T. Ross, Little Rock, secretary.

R. L. Taylor has been discharged from military service and has returned to practice at Conway.

C. G. Leverett has been discharged from military service and will be associated with the Holt-Krock Clinic, Fort Smith.

COMMUNIQUE

Dec. 20, 1944.

To the Editor:

I have enjoyed The Journal and Random Thoughts very much in the past and wish that pleasure to continue, consequently, I am enclosing my permanent APO address. I am on one of the ** islands.

Living conditions were rather rugged for a while, but now everything is under control except the weather. We have yet to see a day without a downpour.

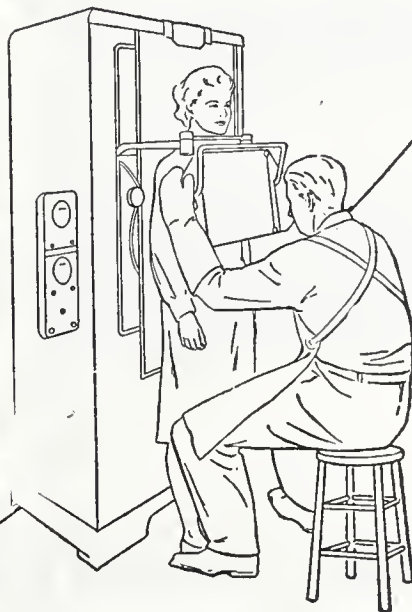
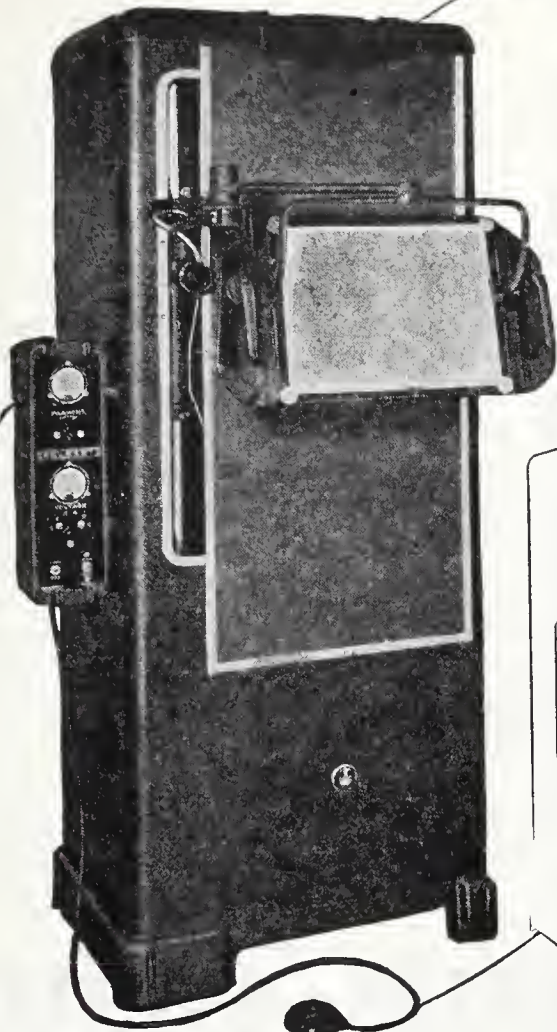
Thanks a lot for sending the literature. It helps a lot to know what is going on back home.

Yours truly,

Philip T. Cullen, Capt., M. C.

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LITTLE ROCK, ARK.

COMMUNIQUE

January 7, 1945.

To the Editor:

Though my correspondence has lagged with the State Society, it certainly doesn't mean that my interest in the homeland has waned and I am very happy that delivery of The Journal and the regular issue of Random Thots do not depend on active correspondence. Each issue is carefully read and all of it enjoyed. To all of those who are responsible for this good work, we who are absent extend grateful thanks. You have probably noted that we have incurred a change in address and if my mailing address would be changed to the above, I will have the privilege of receiving my copy a bit earlier.

All continues well with me. We are living completely under tentage, have open air showers but are fortunate to have lights, running water and a satisfactory mess. Understand that Phil Cullen is in this area and after we become organized, hope to look him up. There is little of interest to report from this area at this time and in closing let me take this rather belated opportunity to extend my good wishes for a successful New Year to all.

Sincerely,
John E. Greutter, Maj., M. C.

COMMUNIQUE

December 31, 1944

To the Editor:

Just received your Random Thots and, as usual, was glad to hear from the Arkansas boys. Sorry to see that so many have not sent in their addresses and hope that they will be able to later.

I am always glad to get your stories, since good ones are scarce here for some reason. Maybe because Dr. Owen Agee, another Arkansas boy, has been temporarily at Delgado Memorial Hospital instead of his usual trips over the state. Also I have had to do some traveling to "cover" for him at the Oakdale, Louisiana, and Glenmore, Louisiana, clinics.

In my spare time I did a little work with some oil paints and some scrap iron and wires to make my own Christmas decorations. Enclosed is a clipping from our paper telling about it.

Sincerely,

William L. Bunch, Jr.,
U. S. Public Health Service
3342 Hiawatha Street
Baton Rouge, Louisiana

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COMMUNIQUE

December 26, 1944.

To the Editor:

Our Christmas here was much nicer than our last one in this country. You know, it is our second one here. The Army did a swell job getting our mail and Christmas packages to us in adequate time for Christmas.

We, each man, received four bottles of real American beer, the first we have seen in one year. The officers received a fifth of Argentine gin which we pooled and gave our men a party Christmas Eve night. Sang lots of songs and everyone in good spirits when the party broke up. We made us a Christmas tree and decorated it with the paper from our Christmas boxes, dipped the pine cones in plaster paris to make them white. When we were finished it looked real nice. You can count on GI's when it comes to something like this.

It is quite cold in this tent now. We have three dogs, or pups, which we are raising for watch dogs. They are all curled up around the little fire we have. One of them already barks at night, so he probably will teach the others.

Am still quite busy. Will close, wishing you a Prosperous and Very Happy New Year.

Sincerely,

Hunter A. Causey, Capt., M. C.

WOMEN'S AUXILIARY NEWS

Dear Auxiliary Members:

Our Auxiliary year is passing and it may be well to remind you of our Student Loan Fund.

We have only three loans outstanding and they are to men in the service. So far we have not lost any of our principal on over seventy loans.

When the government discontinues its educational program, we shall again have many requests for loans. This year was the first time the medical school graduating class did not include any one to whom we had made a loan. In one class not long ago there were twelve whom we had helped. That ought to make every member feel that she has had a part in a worth-while project.

Money seems to be plentiful now, so now is the time for each Auxiliary to put forth a special effort to raise an extra large amount to contribute to our fund before the annual meeting in April.

Please send your contributions to me, not to the treasurer.

Mrs. Chas. E. Oates,
4 Scenic Road
North Little Rock

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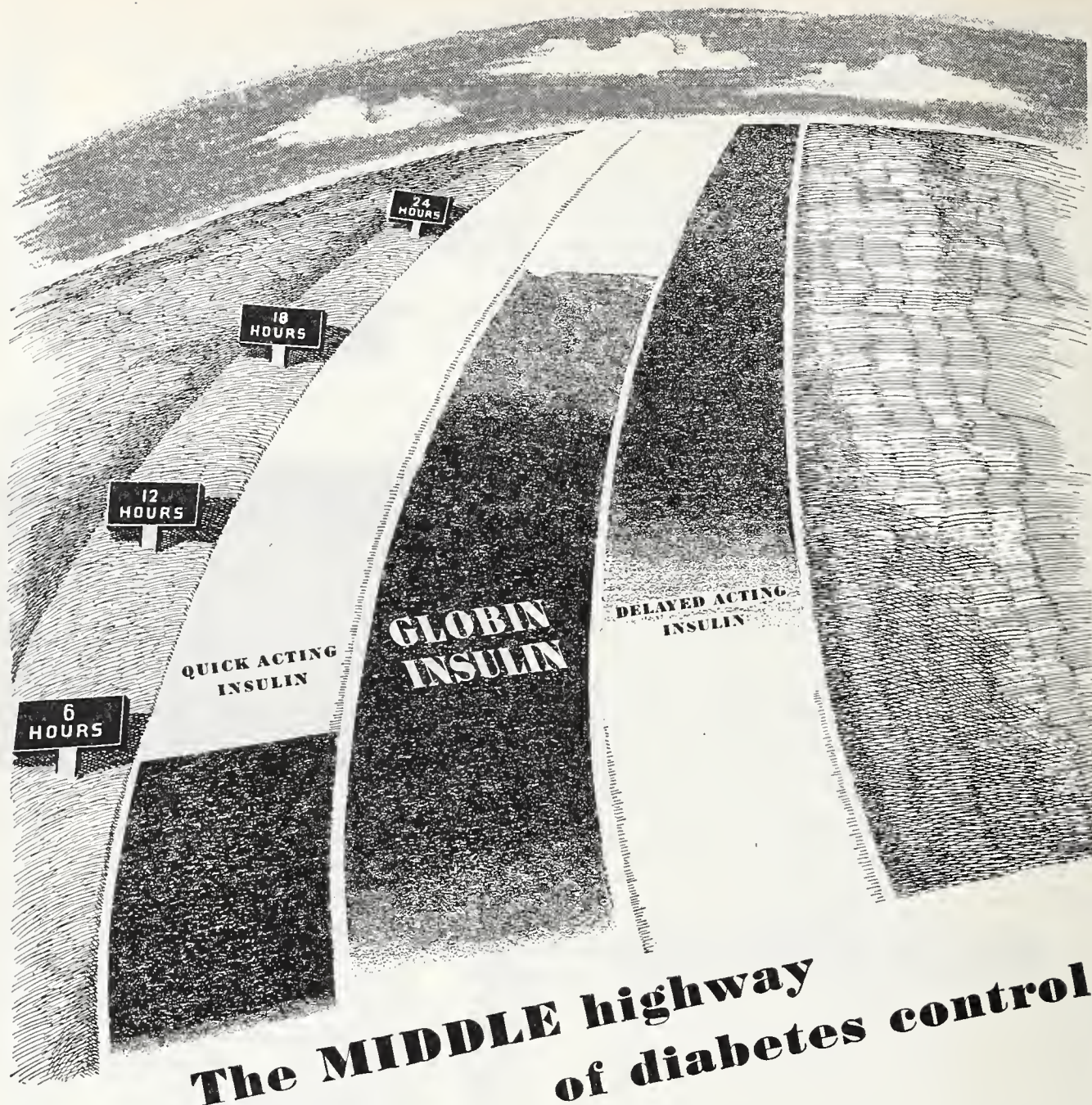
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The JOURNAL

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PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL.

Vol. XLI

LITTLE ROCK, ARKANSAS, MARCH, 1945

No. 10

NEWER METHODS OF TREATING THE MENTALLY ILL*

N. T. HOLLIS, M. D.
Little Rock

In our State Hospital we are helping more mental patients now than ever before. There are two chief reasons for this. In the first place, you doctors throughout the state are giving us invaluable help. You are sending in cases earlier, bringing them in personally in many instances, and building in the minds of the patients and their families the conception that the hospital is the place to get well and not a place of last resort or a place to be feared and avoided if possible. You are changing the attitude of the public toward mental disease. No longer is the mental case hopeless. It can be cured. People are accepting the fact that mental diseases happen in the best of families, that they are not stigmatizing, and if treated early almost all cases can be cured. This change in the mind of the public is most fundamental and basic. In the presence of such a change, the patient comes in earlier with a receptive mind rather than a resentful one. His family is helpful rather than antagonistic. Any treatment is accepted rather than resisted. For your fine efforts to educate the public toward mental disease we are truly grateful. Through these efforts we will be able to do more for your patients here.

Secondly, the advent of newer methods of treatment have been most stimulating to those of us in the mental field. Many of our former cases that have been looked upon as hopeless are now responding to treatment and are going back into society as useful, producing citizens. Perhaps the most outstanding newer treatment is shock therapy. We have used various forms of this treatment for the last five years, starting with insulin shock, then metrazol, and the latest, electric shock. Electric shock we have found to be most effective, the simplest, and the safest. We had one death from insulin shock, but have

had no fatalities or unusual complications among our electric shock patients. We feel that we can be justly proud of this record, as there have been a few fatalities and many distressing complications in other institutions. All credit should be given to the head of this department, Dr. J. H. Koenig, and his fine assistants whom he has trained so thoroughly. All patients going through this department are checked carefully, X-rays made of their chests and spines and, if indicated, electrocardiograph studies of the heart are made. This form of treatment we use now in our cases of dementia praecox, depressed cases of all kinds, and especially our involutional cases. To send these most distressing people home in just a few weeks, happy once more, is a most satisfying experience. At home they are spreading the idea that the State Hospital is a place in which to get well. The results from the use of shock therapy in depressed cases are most remarkable, to such an extent that we think it almost a specific. This is the experience in institutions of this kind throughout the country. Our results in our cases of dementia praecox, although most encouraging, are not nearly as spectacular as in our depressed cases. We also use shock treatment in quieting our highly disturbed maniacs. We are demonstrating our shock equipment here for any of you doctors interested in the actual technique.

With the installation of a definite, artificial fever department in connection with our anti-luetic treatment, we are getting results never obtained heretofore. We have proved to our satisfaction that continuous and adequate treatment will reverse both blood and spinal fluid Wassermanns. Fever treatment is a definite adjunct in getting these reversals. Because of our results in helping cases that have seemed to be losing ground in spite of anti-luetic treatment outside, we feel that the routine, regular life here in the hospital away from the emotional stress and strain of homelife plays a big part in the treatment. In some cases this additional help may tilt the scales toward cure, whereas without it, the patient may continue to go down even with the best ambulatory treat-

*Read before the Sixty-ninth Annual Session, Arkansas Medical Society, Little Rock, April 17, 1944.

ment. This point is one that you can help us get across to the public. Leave the patient here until well, rather than to yield to his plea to be taken home before he is well.

This past year with the addition to our staff of Dr. Robert Watson, neurological surgeon, on part-time basis, we have been able to diagnose more adequately our neurological cases. A number of brain tumor cases have been successfully operated and diagnostic encephalograms made where indicated. Our neurological staff each week has made us increasingly conscious of the neurological aspects of our patients and has given us a better understanding of the underlying pathologies.

We think we have the answer to the problem of the chronic alcoholic. This answer we feel is in our affiliation with the group, Alcoholics Anonymous. This is a group of ex-alcoholics banded together in a religious order, and which has a most unique approach to the problem. The results speak for themselves. Here in Little Rock there are more than sixty members of the Group, many of whom had been in our hospital time after time, and had been given up as hopeless by all concerned. To see these men remain sober month after month and the very remarkable change which has taken place in their personalities is, to the writer, a modern miracle. Perhaps this association of science and religion portends greater things yet to come through such associations.

These cases, dementia praecoxes, manic depressives, involuntions, paretics and alcoholics make up about one-third of our admissions, but because of their chronicity they make up over one-half of our patient population at any one time. With the use of these newer therapeutic measures, we are glad to report that the percentage of these cases is slowly decreasing. They are going back into society.

The results through the use of these newer methods has created new hope in the minds of everyone concerned with mental disease. With this new hope will come the dawn of yet better days.

COMMUNIQUE

To the Editor:

Having moved a few thousand miles west, I thought you should be advised, genuine evidence that I continue to appreciate The Journal as well as the other literature afforded those on your mailing list.

Best wishes.

Gaston A. Hebert,
Lt. Comdr., M. C., USNR

MODERN CONCEPTS OF CARDIO-VASCULAR DISEASE

COMMITTEE ON THE HEART
ARKANSAS MEDICAL SOCIETY

C. T. CHAMBERLAIN, M. D., Chairman
Fort Smith

ESSENTIAL HYPERTENSION Part II

Symptoms and signs: Essential hypertension is often discovered incidentally in the course of routine physical examination. In other instances, insomnia, restlessness, headache or a vaguely described "nervousness" or "tenseness" may first bring the patient to his physician. In the benign form of essential hypertension organic changes develop slowly and symptoms may be trifling even over a period of 15 to 20 years. The symptoms are usually those of cerebral thrombosis and hemorrhage, coronary sclerosis and thrombosis, or slowly advancing cardiac failure, singly or together. In the malignant form the symptoms of hypertensive encephalopathy, cardiac failure and renal failure are seen in various combinations within six months to three years from onset and progress very rapidly.

The most important and earliest sign is, of course, an elevated diastolic and systolic arterial blood pressure, which persists after the patient has recovered from the excitement of a first examination. Prolonged emotional tension may, however, produce a mild hypertension for days or weeks which, after reassurance or resolution of the emotional conflict, gradually subsides. In such cases the prognosis is better than would be expected at the initial examination.

Palpation of the superficial arteries, ophthalmoscopic examination of the retinal vessels, urinalysis and kidney function tests will make clear the degree of vascular change in these respective regions. Signs will vary because the regional distribution and intensity of arteriolo- and arteriosclerosis differ widely from patient to patient. Thorough examination of the heart with the necessary special studies will reveal hypertrophy, coronary sclerosis and signs of failure. Prognosis and the nature of therapy will naturally depend upon the system in which breakdown is most threatening.

Every patient with hypertension should have prompt study by means of intravenous urography and if necessary urine cultures, cystoscopy and retrograde pyelography, in order to detect at

the earliest possible moment any correctible abnormalities of the urinary tract. These abnormalities do not always produce characteristic symptoms, and will be overlooked unless these studies are done routinely.

Diagnosis and prognosis: Having decided that hypertension really exists by finding significant and consistent elevation of both systolic and diastolic pressures, the systematic and thorough use of modern diagnostic methods makes it quite impossible to rule out very definitely other conditions that must be excluded before the diagnosis of essential hypertension can be made. Most important in this respect are coarctation of the aorta, polycystic kidney disease, congenital anomalies, glomerulonephritis, pyelonephritis and medullary or cortical tumors of the adrenal glands. When hypertension is due to a unilateral renal lesion early diagnosis is particularly important. The success of treatment by unilateral nephrectomy is greatest in young patients and in those whose hypertension has not existed long enough to produce secondary changes in the heart, the peripheral vessels and the other kidney.

The prognosis of true essential hypertension depends upon several factors and requires repeated study at intervals of months or years to gauge accurately the rate at which the sequelae of persistent hypertension are appearing or advancing. The higher the blood pressure, and particularly the higher the diastolic pressure, the graver is the prognosis in general, though this rule is by no means infallible. Certainly, a diastolic pressure of 150 mm. Hg or more, even though that level is reached for only brief periods, presages the malignant phase and is followed before long by severe symptoms. Hypertension in patients below 35 or 40 years of age is more apt to run a malignant course, than is the case with hypertension beginning at age 45 or older. Retinal hemorrhages, exudates and particularly papilledema signify a poor prognosis. The same is true of cardiac failure and renal failure, singly or together. On last analysis, it is the severity and localization of organic arteriolar disease, rather than the blood pressure per se, which indicates prognosis. Women, during the menopause, and obese patients in general often do better under medical treatment than might be expected at first examination.

Treatment: A specific treatment of essential hypertension is still not available despite painstaking effort on the part of clinical investigators for many years. Treatment by medical and by surgical means is at best symptomatic but offers a great deal to the vast majority of patients. An

optimistic and understanding attitude on the part of the physician is essential. Patients should not be permitted to know, or become preoccupied with, the inconsequential and spontaneous fluctuations of blood pressure characteristic of this disease. It is far more important that they should be encouraged by reiterated instruction to adopt the "way of life" most apt to ensure longevity.

In the apprehensive, tense, hard-working patient resolution of emotional problems, reassurance, regular and frequent rest or vacation periods, mild exercise suited to the cardiac reserve, and the judicious administration of sedatives such as phenobarbital or chloral hydrate in small doses will usually be helpful symptomatically whether or not the blood pressure itself is greatly lowered. Relaxation may be secured in some patients by warm baths or massage. Alcohol, coffee, and tobacco can be used in moderation except by those patients who are sensitive to their effects.

Manipulation of diet have no lasting effect on hypertension with the single reservation that in obese patients general restriction of caloric intake producing a gradual loss of weight, is often accompanied by significant lowering of blood pressure and by improvement of symptoms. Restriction of salt intake is indicated only when the edema of cardiac failure appears. In some patients headache may be relieved by sleeping with the head of the bed slightly elevated, or by cautioning them against drinking large volumes of water in brief periods. Nevertheless as the concentrating power of the kidneys becomes less, the 24-hour intake of water may have to be greater than normal to permit a compensatory polyuria.

Drugs of the vasodilatory group such as amyl nitrite, nitroglycerin, sodium nitrite and theophylline are useful only during hypertensive paroxysms and even then should be reserved for specific indications or to reduce the blood pressure from a sudden dangerous elevation. Estrogenic preparations are worthy of trial in the hypertension of women coinciding with the climacteric. Bismuth subnitrate, insulin-free pancreatic extract, and vegetable substances such as cucurbitacin or garlic have no significant effect.

Potassium thiocyanate in a daily dose of 0.3 to 1.0 gram carefully adjusted for each patient to produce a blood level not above 10 mg. per 100 cc., is reasonably safe providing blood levels are determined frequently. In 30 to 40 per cent of patients this carefully controlled dosage reduces blood pressure slightly, and relieves headache, insomnia or the general tenseness of which these patients complain so frequently. Its effi-

cacy is less in severe hypertension and diminishes as organic changes progress. The patient should be cautioned to discontinue the drug immediately if skin eruptions, weakness, lethargy, nausea or vomiting appear.

The renin and amine theories of the pathogenesis of essential hypertension have each served as the basis for attempts at specific therapy, but these are still in the purely experimental stage and need not be described fully here. Kidney extracts and a preparation of tyrosinase have reduced hypertension in animals and man, but with both agents local tissue reactions and fever are common. Recent reports ascribe their effects to a non-specific foreign protein reaction. Such reactions in hypertensive patients are unpredictable as to severity and may be quite dangerous. At the present time it appears that none of these substances are dependable enough for general commercial distribution.

The surgical treatment of true essential hypertension has had a checkered career. The proved usefulness of unilateral nephrectomy in carefully selected cases of "renal" hypertension produced by disease of one kidney has been referred to above. Omentopexy to the denuded surface of the kidneys has not been effective. Subtotal adrenalectomy has been tried and discarded. In general anterior root section and supradiaphragmatic splanchnicectomy are not as advantageous as combined lumbodorsal splanchnicectomy. Because so much depends upon the benign or malignant nature of the disease and, particularly, the exact stage at which the operation has been performed, conclusions as to the effect of operation on longevity, kidney function and symptoms have been hard to assess. Skeptics have called attention to the nonspecific effect of laparotomies, e. g., for myoma uteri, on symptoms and even blood pressure of hypertensive patients. Nor has experimental hypertension in dogs been reduced by any of the operations now in vogue. It should be emphasized, however, that a silver clamp on the dog's renal artery is not the same as the arteriolar spasm that characterizes early hypertension in man.

For these and other reasons, physicians generally hesitate to urge operation for patients in the very early, almost asymptomatic stages though greatest effect is obtainable only at this time. Later, when the functional capacity of the kidneys and heart has been reduced, operation is of no avail. In general, patients over 50 years of age are not suitable for operation. Smithwick summarizes the surgical viewpoint as follows, "When the indications for operation are clearly

defined it is to be expected that a high percentage of carefully selected patients will benefit, as judged by persistent and significant lowering of blood pressure levels. Regression of eyeground changes, decrease in the size of the heart, improvement in the electrocardiogram, improvement of renal function and relief of symptoms are noted in certain cases, and present additional ways of evaluating the results of surgery. Furthermore, time may show that life expectancy is increased. There can even now be no doubt of such an increase in cases of malignant hypertension and in patients with severe retinitis who have been subjected to adequate surgery before renal and cardiac functions have been seriously impaired. At the present time, surgery appears to offer the greatest hope for these patients."

The mortality from operative treatment by a surgeon experienced in this field is small. It seems likely that sympathectomy should be recommended much more often and much earlier than is the case now even though available evidence indicates that this operation represents symptomatic rather than etiologic treatment. A closer consultative relationship between physician and surgeon is essential. In the meantime, however, vigorous search for more specific, direct and rational therapy should be continued.

Acknowledgment is hereby made of permission by the American Heart Association to publish the above.

COMMUNIQUE

February 4th, 1945

To the Editor:

Was very pleased to receive Random Thots the other day. This was the first copy I had received in some time. Keep 'em coming. These certainly help us to keep in touch with what is happening at home as well as where many of the boys are. I haven't received any copies of The Journal since I've been overseas. I would like to get it. Send the bill to my wife.

Yes, I have heard of rotation. It seems as though when the war is over, the plan might possibly begin working. This plan, however, doesn't particularly worry many of us here, however, for, as long as we are in the army, we had rather be here than in the States.

Regards to all—hope to hear from you soon.

Fraternally,

Thos. S. Van Duyn,
Lt., M. C.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

THE proper feeding of patients in tuberculosis hospitals is a difficult task at best. Supervising an adequate diet for patients treated at home calls for even greater ingenuity. With wartime shortages and increasing costs the problem in either case is further intensified. The importance of nutrition as an aid to therapy and a factor in maintaining patient morale must not be overlooked or underestimated.

DO WE FEED TB PATIENTS PROPERLY?

Has the pressure of the war changed our feeding of the tuberculous patient? Is a relaxation of our policy of "plenty of good food" of serious concern in the treatment of tuberculosis? What should be the goal of the dietitian in planning the wartime diet? These are questions in the minds of those interested in the care of tuberculous patients.

Personal observations have indicated that the standards of nutrition have been relaxed in some institutions, partly because of expense and, at times, because of scarcity. How general this lowering of standards has become is not known, but it is thought to be considerable.

In order to assess the significance of relaxing the policy of "plenty of good food" we must know the nutritive status of "well fed" tuberculous persons before the war. Nutritional surveys have shown that many tuberculous persons, even those on a good sanatorium diet were actually malnourished, especially in respect to ascorbic acid and vitamin A. Other food deficiencies were also found. These observations came as a surprise, for clinicians felt secure and were worried about malnutrition only where intestinal disease obviously interfered with assimilation of food.

How important are vitamins A and C in the resistance to tuberculosis? This cannot be answered as yet, but some evidence has been obtained in favor of increasing the intake of these two substances. The cod liver oil and tomato juice "cocktail" prescribed by some in the treatment of tuberculosis is rich in these vitamins. It has been found effective in preventing the development of extra-pulmonary tuberculosis in those with the disease in the lungs.

Empirical use of cod liver oil and tomato juice, now has a scientific basis. We still do not know

the effect of completely abolishing the deficiencies of vitamins A and C or the effect of abolishing all nutritional deficiencies.

During the last war, an experiment was unknowingly conducted on the effect of food on the resistance to tuberculosis. Before the allied blockade of Denmark was complete, much food was sold to Germany for high prices. The latter stimulated sales to such an extent that the Danes were depriving themselves of essential food, so much so that vitamin A deficiency was evident clinically and its ocular manifestation, called xerophthalmia, was found in hundreds of infants.

At this time the death rate from tuberculosis had risen to a wartime high. Later, as a result of the submarine blockade and food rationing, essential foods were left in the country. Tuberculosis began to recede as soon as exports stopped. This is now regarded as a classic observation on the effect of food, for other factors such as crowding, poor housing, fatigue and overwork were still present and unchanged. Xerophthalmia disappeared, too, when the food exports stopped.

The evidence, then, at present is that tuberculous persons are often not well nourished even when "well fed" and that malnutrition is a vital factor in the incidence and course of the disease. Such evidence makes any relaxation of our feeding standards in wartime seem hazardous.

We have learned, too, that it is not the energy content of food that is important. No doubt the Danes replaced the essential food shipped off with food of an equal caloric content. The foods shipped were those high in protein, fat, vitamins and minerals. The substituted food was largely carbohydrate. This focuses our attention on the individual food constituents. What are the important food constituents for the tuberculous person?

Recent appraisal of the nutritional status of the tuberculous patient has brought out that these people are mainly in need of vitamin C, vitamin A, protein and minerals. The requirement of vitamins A and C is so great that it seems impractical to plan a diet with sufficient amounts of these materials to overcome the deficiencies. This then is a problem of therapeutics—the supplemental dose to be governed by the degree of the deficiency.

The diet for the tuberculous person should have an abundant amount of protein—70-100 grams per day. This is in excess of that recommended for healthy people, for the tuberculous person has to replace his depleted stores of protein, and, too, his daily needs are more.

All vitamins are probably needed in greater amounts by the tuberculous person, but we have scientific data only for a few of them. Vitamin D has been singled out for special attention because of its role in calcium assimilation and metabolism. Vitamin K deficiency has been found in tuberculous persons and is of especial concern because of its function in normal blood clotting. Those in need of vitamin K are subject to severe hemorrhages. Part of the inanition in tuberculous persons may be due to lack of the B vitamins. Minerals and calcium in particular are deemed important in the healing process. Phosphorus and iron are thought to be needed in greater amounts by the tuberculous person; phosphorus is utilized with the calcium; iron is necessary in the production of hemoglobin. Secondary anemia is always present in advanced tuberculosis.

The proper diet can be summarized as high in essential foods and low in carbohydrates. The total caloric intake is governed by the amount of carbohydrates given. When the person has gained to approximately his normal weight, the caloric intake should be reduced, leaving the intake of the prescribed essentials the same. The latter should be changed only because of food intolerances and then only after all means of substituting foods have been exhausted. The dietitian's problem is to get the prescribed amounts of the food constituents into meals that will be consumed and tolerated by the patient. It is no easy task.

The diet can be "low cost" and yet provide the essentials. The author and his associates have recommended for persons taking treatment at home a list of reasonably priced items: "Food for Tuberculous Patients."

An analysis of such a food list recently concluded by the Henry Phipps Institute, Philadel-

phia, Penna., showed the total cost to be \$4.69 per person per week. It is obvious that this removes cost as an objection to maintaining the quality of the diet. We are more anxious than ever before to get the tuberculous person well because of the wartime necessity for conserving manpower. Therefore, it is imperative that we continue to improve the diet of the tuberculous person rather than relax our standards.

Do We Feed TB Patients Properly? Horace R. Getz, M. D., *The NTA Bulletin*, September, 1944.

Dr. Joe F. Shuffield of Little Rock, president of the Arkansas State Medical Society, is state chairman for the 1945 Easter Seal Sale of the Arkansas Association for the Crippled, being held during the month preceding Easter Sunday, April 1, simultaneous with the 12th annual sale of the National Society for Crippled Children and its more than 2,000 affiliated county and state organizations throughout America.

The current effort marks the first annual statewide sale of the Arkansas association. Organized little over a year ago by a large number of the state's business, professional and civic leaders in all sections to meet an announced "vital unmet needs other than medical care of the crippled of Arkansas," a limited sale was held in eight counties last year. Slightly over \$9,000 was the response, and, according to Herbert Parker of Jonesboro, president of the association's Board of Trustees, "the association's wide-range programs, which are not duplicated by any other agency, either public or private, were launched in Arkansas as they already exist in practically all other states."

COMMUNIQUE

To the Editor:

Your letter dated 21st of December received also "Random Thots." There must be some error about us getting all the cigarettes. They may go to other theaters but not to * * *. Our January ration was one "Old Gold" and one "Phillip Morris." Don't care for either but smoke them just the same. I don't smoke much therefore it does not cause me any trouble. We are still busy and our hospital is operating on a capacity basis. The news sure does sound good now and I, for one, sure hope it continues. It looks like our road will open up soon, then maybe we can take a well-earned rest.

Best of luck.

Hunter A. Causey, Captain, M. C.

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W. R. BROOKSHER, M. D., Editor
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EDITORIAL

WHAT THE PEOPLE THINK ABOUT
MEDICINE AND MEDICAL SERVICE

In July, 1943, the National Physicians Committee employed the largest opinion research group in this country to make a comprehensive study of the people's opinion about medical care. The results of that study have just been made available. In making this survey the National Physicians Committee has rendered a distinguished service to American medicine. The report should be of great help to medical leaders by pointing the way in planning for the extension of medical service. The report indicates the necessity for more education of the public regarding the issues involved in proposals for changing the nature of medical service. When people understand the issues, an overwhelming majority are unqualifiedly opposed to any such proposals as the Wagner-Murray-Dingell bill, which would establish federal control of medical practice. Even though the people sense the need for the extension of facilities designed to meet the costs of unusual or prolonged illness, only a small minority, as shown by this report, believe that compulsory sickness

insurance would provide a satisfactory solution to the problem.

Many of the questions in this research concerned the personal experiences of the people with medical care as now provided in the United States. The replies, in great majority, indicated that the people are deeply conscious of the value of individualized service in the effectiveness of medical care, that they want complete freedom of choice in time of illness and that they believe choice would be limited and restricted by administration of medical care under the auspices of the federal government.

Out of this report came the conviction that many persons find difficulty in meeting bills for unusual or prolonged illness and desire to participate in plans or methods for insurance against the hazards of emergency illness. Already great numbers of people are familiar with the various prepayment plans for medical service available throughout the country. The investigations extended into many communities in which such plans are operating and covered the experiences of the participants. To summarize the many questions asked on this phase of the report: Persons who participate in prepayment plans approve them; in every instance such persons believe they are better off than their neighbors who have no such opportunity; the doctors in areas where such plans are in operation believe that the people are better off because of the operation of the plan. More than 50 per cent of the doctors in such areas stated that it would be a good thing if all industries would operate prepayment medical and hospital service plans for their employees.

In a special survey, paralleling the study of medical service, opinion was sought concerning the American Medical Association. More than three-fourths of the people who were questioned had heard of the American Medical Association, and about half of these defined its purposes with reasonable accuracy. In general, those who had heard of the American Medical Association expressed approval. The inquiry about the American Medical Association was made in the survey to determine the extent to which mention of the public education activities of the medical profession would tend to have a favorable or unfavorable influence on public thinking. The best evidence that the American Medical Association was considered a "favorable symbol" was the fact that most people think of the purposes of the American Medical Association as being "to sponsor new medical technics; to keep the standards of medical practice high; to give endorse-

ment to acceptable medical products." Moreover, less than one-tenth of the people interviewed thought of the American Medical Association as a "union" of physicians or as a "trust" or as being otherwise primarily a self-interested body.

The report of this survey, which is available through the National Physicians Committee, should do much to counteract the irresponsible and sometimes malicious criticisms that have been expressed recently within and without the medical profession. The scope and the accuracy of this survey cannot be questioned. The results are a challenge to medical leadership. Only through enlightened medical leadership can medical service and medical science continue to evolve in the United States beyond the high point that they have now attained. The advancement of medical science and of medical education is fundamental to the quality of medical service. Some of the proposals that have been made to federalize medical service, coming from outside the medical profession, would subsidize education and research. From within have come proposals to "unionize" or "commercialize" medical service. The professional status of medical care and medical science must be maintained. The economic factors involved in securing wider distribution of medical service must be studied and the widest possible application of these services secured. But even the economics of medical service must always be dependent on the science, the art and the practice of medicine.—Journal A. M. A., March 11, 1944.

EDITORIAL COMMENT

PROPOSED AMENDMENT TO THE BY-LAWS

The following amendment to the By-Laws of the Society was proposed at the 1944 annual session and will be acted upon at the next annual session:

Resolved, that the By-Laws of the Arkansas Medical Society be amended substituting the following:

"An active member who shall have attained his eightieth year and shall have been a member of his county medical society in Arkansas or elsewhere in the United States continuously since beginning the practice of medicine, or who for fifty years shall have been continuously a member of his county medical society in Arkansas or elsewhere in the United States, shall, upon establishing the above facts to the satisfaction of his county society, and upon the recommendation of such society, be granted the status of a life

member. Such member shall enjoy full membership privileges and shall be exempt from the payment of further dues or assessments. An active member in good standing in his county society may, upon the recommendation of such society, be granted affiliate membership with full voting and other privileges where one or more of the following conditions exists: retirement from practice; physical or other disability of a character preventing the practice of medicine; a serious and prolonged illness; or financial reverses.

"Affiliate membership shall be on an annual basis only and a member must be recommended each year for such special status by the secretary and president of his county medical society following a review and reassessment of his particular situation. An affiliate member shall enjoy full membership privileges and shall be exempt from the payment of dues and assessments during the year in which he is granted such status, and a certificate of membership shall be issued to him for such year."

1945 ANNUAL SESSION CANCELED

At the request of the Office of Defense Transportation and as a patriotic move, the Council has canceled the 1945 annual session of the Society originally scheduled at Little Rock on April 23rd and 24th. This action is in line with the decisions of other state and national medical organizations. In the directive requesting cancellation of all meetings not directly related to the war effort, provision was made for organizations to request approval to hold meetings. Under present regulations it is not possible to hold a session of the House of Delegates separate from the customary combined general session. Of 222 organizations making such requests, the committee having jurisdiction granted approval to two organizations, as of February 15th.

In lieu of the annual session the Council will meet April 22nd for the transaction of such business as may properly come before that body. County societies, committees and members having matters which require the attention of the Council are urged to notify the state secretary at the earliest possible date in order that arrangements may be made for consideration.

RANDOM THOUGHTS OF THE SECRETARY

January 27th. Now a bulge is driven in our Montgomery Ward theater of operations.

January 30th. Additional successful prosecution of the war note: Vice-president Truman travels to Kansas City in an army bomber to attend the funeral of "Boss" Pendergrast.

February 1st. Tonight the "brown-out" takes those

vivid neon signs out of circulation for an indefinite period but we quickly observe that they added to the general illumination of our streets and pedestrians should now become even more cautious.

February 5th. Comes Miles Kelly visiting, an authority on a car with Stanley Gates, Fount Richardson and Byron Bennett when it comes to a discussion of "permanent" rank in the army medical corps.

February 7th. Tonight en route to Kansas City we converse with attorney Moore of Harrison, now in naval service, who can give new lights on the activities of Gladden and Owens.

February 8th. All afternoon and evening with the College of Radiology where we demonstrate our mastery of technicalities to Cahal, Lockwood and Allen, should we eventually profit on these wagers. Hearing from Dabney Kerr of the activities of George Burton, now a resident in radiology, and who has learned that you may smoke a pipe in your Bald Knob office, but not in the University of Iowa examining rooms.

February 9th. To breakfast and amazed at the Colorado-inspired appetite of Wasson and happy to see the D. A. Rhineharts, the better half of whom receives our unnecessary urging to visit the Weathered and Saks shops while in Chicago. During the day the color question is revived for the Southern chancellors who constitute a minority group on this occasion.

February 10th. Busy with the concluding activities of the day, finding this a session which sifts the problem in all earnestness and it may be said that the affairs of radiology are conscientiously managed. Away to the airport with but a glimpse of the Loop but first passing compliments to the Drake Hotel, where the staff is determined that service shall not deteriorate, succeeding well in that aim.

February 13th. Tonight George Fletcher discusses various neurological findings and conditions before the county medical society and after adjournment, Blair unsuccessfully attempts to convert George to the theory of alcohol as an etiologic agent in the production of neuritis.

February 21st. On the fringes of matters legislative tonight with a brief pause in the Marion lobby and then engaged in discussion with tuberculosis-minded individuals in drafting a bill for compulsory chest X-ray examinations of school employees—a commendable aim.

COMMUNIQUE

To the Editor:

Reading "Random Thots" today reminded me that a year ago, I talked to you on the phone. Had just been put in 4F but Selective Service had called for an interview. You said you thought it was a mistake and that I would not pass. After a year, I am beginning to believe you were wrong. It isn't bad here in * * *. Had a nice chat with Major Reagan, Marked Tree, several weeks ago, only one I have seen from Arkansas. * * * hospitality is wonderful. They really do everything they can to help out. Keep "Random Thots" coming, also The Journal. Helps a lot. Above is the new APO. As they say here, "You've had it, old chap, you've had it."

Sincerely,

Chas. P. Harris, Captain, M. C.

PROCEEDINGS OF SOCIETIES

The Pulaski County Medical Society was addressed February 5th by Lt. Col. Daniel H. Autry and Lt. Col. Paul V. McCarthy, Station Hospital, Camp Robinson, on "Atypical Pneumonias."

L. L. Fatherree, Secretary.

Miller County Medical Society has elected the following officers: President, N. B. Daniel; Vice-president, William Hibbitts; Secretary-treasurer, Geo. W. Parson; Delegate, H. E. Murry, and Alternate, R. R. Kirkpatrick.

Lonoke County Medical Society has elected the following officers: President, E. A. Callahan, Carlisle; Vice-president, O. D. Ward, England, and Secretary-treasurer, F. A. Corn, Lonoke.

The Ouachita County Medical Society met in regular monthly dinner-session February 1, at the Camden Hospital. The program consisted of a round-table discussion of medical problems which have arisen in this vicinity due to the new Naval Ordnance Plant which is being constructed here.

R. B. Robins, Secretary.

Ashley County Medical Society has elected M. C. Crandall, Wilmot, President, and L. C. Barnes, Hamburg, Secretary-treasurer.

Faulkner County Medical Society has elected the following officers: President, J. S. Lieblong, Greenbrier; Vice-president, E. N. Fraser, Conway; Secretary-treasurer, I. N. McCollum; Delegate, C. A. Archer, Jr., Conway, and Alternate, J. R. Downs, Vilonia.

While County Medical Society has elected the following officers: President, Porter R. Rodgers; Vice-president, W. H. Wilson; Secretary-treasurer, S. J. Allbright; Delegate, A. H. Hudgins, and Alternate, M. C. Hawkins, Jr.

Chicot County Medical Society has elected the following officers: President, B. C. Clark, Lake Village; Vice-president, W. A. Craig, Eudora; Secretary-treasurer, M. K. Bottoroff, Lake Village; Delegate, J. H. Burge, Lake Village, and Alternate, B. C. Clark.

The Cleveland County Medical Society has re-organized, electing the following officers: President, S. C. Johnson, Kingsland, and W. G. Hancock, Rison, Secretary.

Garland County Medical Society has elected the following officers: President, O. A. Smith; Vice-president, L. E. Reed; Secretary-treasurer, W. E. Gray; Delegates, J. M. Proctor, J. S. Stell and C. E. Garratt, and Alternates, G. C. Coffey, Foster Jarrell and D. C. Lee.

Desha County Medical Society has elected the following officers: President, H. A. Rands, Dumas; Vice-president, Gibbs Biscoe, Dumas; Secretary-treasurer, Swan B. Moss, McGehee; Delegate, H. T. Smith, McGehee, and Alternate, H. A. Rands.

The Craighead-Poinsett County Medical Society met in regular session February 1st for a discussion of prepaid medical care plans and hospitalization insurance. Speakers were L. H. McDaniel, R. C. Shanlever, Ira W. Ellis and P. W. Lutterloh.

J. H. McCurry, Secretary.

The Miller-Bowie Counties Medical Society met in dinner session February 16th for the following program: "Hypertension," O. C. Melson, and "Liver Function Test," M. J. Kilbury, both speakers of Little Rock.

Geo. W. Parson, Secretary

The Benton County Medical Society met in dinner session at Siloam Springs February 8th with the program furnished by the physicians of that city.

Geo. M. Love, Secretary

Greene County Medical Society has elected the following officers: President, R. J. Haley; vice-president, W. E. Ellington; secretary-treasurer, W. McD. Lamb; Delegate, Earle D. McKelvey, and Alternate, J. A. Dillman.

Conway County Medical Society has elected the following officers: President, H. E. Mobley; Secretary-Treasurer, C. E. Etheridge; Delegate, H. E. Mobley, and Alternate, C. E. Etheridge.

Arkansas County Medical Society has elected the following officers: President, E. B. Swindler; Vice-President, Arthur Fowler; Secretary-Treasurer, S. A. Drennen; Delegate, R. H. Whitehead, and Alternate, S. A. Drennen.

Grant County Medical Society has elected the following officers: President, O. R. Kelly, and Secretary, Miles F. Kelly.

Washington County Medical Society has elected the following officers: President, W. H. Mock; Vice-President, Loyce Hathcock; Secretary-Treasurer, Ruth E. Lesh; Delegate, J. P. Delaney, and Alternate, Ruth E. Lesh.

Lafayette County Medical Society has elected the following officers: President, F. E. Baker; Vice-president and secretary, A. W. Keith, and Delegate, A. W. Keith.

Lawrence County Medical Society has elected the following officers: President, W. S. Kendall, Cave City; Vice-president, W. W. Hatcher, Imboden; Secretary-treasurer, Chas. D. Tibbels, Black Rock, and Delegate, J. C. Land, Walnut Ridge.

Columbia County Medical Society has elected the following officers: President, L. A. Longino; Vice-president, Jos. F. Rushton, and Secretary-treasurer, John H. Wilson.

THE "CONTINENTAL" BREAKFAST IS NOT SUITABLE FOR A GROWING CHILD

In far too many homes, a breakfast of a roll and a cup of coffee is the fare for children as well as adults. Woefully deficient in vitamins and minerals, such a meal furnishes little more than a small amount of calories. A dish of Pablum and milk, however, is just as easily prepared as a "continental breakfast," but furnishes a variety of minerals and the vitamin B complex, not found so abundantly in any other cereal or breadstuff. The addition of a glass of orange juice and one Mead's Capsule of Oleum Percomorphum can easily build up this simple breakfast into a nourishing meal for the children of the family as well as the adult members. It is within the physician's province to inquire into and advise upon such nutritional problems, especially since Mead Products are never advertised to the public.

COMMUNIQUE

February 6, 1945

To the Editor:

Am back in the United States and have been receiving your letters fairly regularly. Would you please change my address? Thanks for sending them.

Vincent E. Mazzanti,
Captain, M. C.,
Bushnell General Hospital,
Brigham City, Utah.

PERSONALS AND NEWS ITEMS

Capt. Huie H. Smith, Little Rock, who has been on duty in Greenland, visited home on leave during February.

Lt. Jess P. Champion, Little Rock, who has been on duty with the Navy in the Mediterranean and European theaters, visited home on leave during February.

BORN—to Captain and Mrs. J. K. Thompson, Fort Smith, a daughter, on February 5, 1945.

Capt. Vincent Mazzanti, Little Rock, is now hospitalized at Bushnell General Hospital for wounds received in the Pacific theater.

Maj. Jerome S. Levy, Little Rock, is now stationed overseas.

Geo. B. Fletcher, Hot Springs National Park, has been reappointed to the Board of Trustees of the State Hospital for Nervous Diseases.

Lt. Comdr. John N. Roberts, Little Rock, is now stationed aboard ship in the Pacific theater.

The Regional Conference of the American College of Physicians in Memphis was addressed by Chas. T. Chamberlain, Fort Smith, "Chronic Constrictive Pericarditis with Report of Four Cases," and Geo. B. Fletcher, Hot Springs National Park, "Underwater Therapy of Joints with Impaired Function."

John C. McAdams has moved from Pangburn to Bradford.

H. E. Mobley has been elected president of the Morrilton Chamber of Commerce.

BORN—A daughter, Judith Kay, to Dr. and Mrs. Jeff Baggett, Prairie Grove, on January 3, 1945.

B. L. Bailey, recently of Sterlington, Louisiana, has returned to Star City.

Capt. Robert W. Boyle, Little Rock, is now on duty at the United States Military Academy, West Point, New York.

Melvin R. McCaskill, Little Rock, has been called to active duty in the Naval Medical Corps

and assigned to Camp Elliott, San Diego, California.

John H. Wilson, Magnolia, has been appointed a trustee of the Third District Agricultural and Mechanical College, Magnolia.

D. L. Mask has moved from Hamburg to Bearden.

Lt. John M. Hundley, Little Rock, is now assigned to U. S. Naval Hospital, Memphis.

Capt. Cyril L. Hyatt, Little Rock, is now stationed overseas.

Fred Hames, Pine Bluff, attended the recent meeting of the American Cancer Society in New York.

Maj. Virgil E. Lyons, Little Rock, is now stationed overseas.

Lt. Asa C. Watson, Little Rock, is now stationed at Biggs Field, El Paso, Texas.

A. S. Buchanan, Prescott, has been appointed to the Arkansas State Board of Health.

John P. McAlister has been appointed medical director of the Naval Ordnance Plant at Camden.

Ralph E. Crigler has been elected a director of the Fort Smith School Board.

Lt. John S. Agar, Little Rock, has been awarded the Presidential Unit Citation of the 2nd Marine Division for bravery in action on Tarawa.

COMMUNIQUE

February 2, 1945

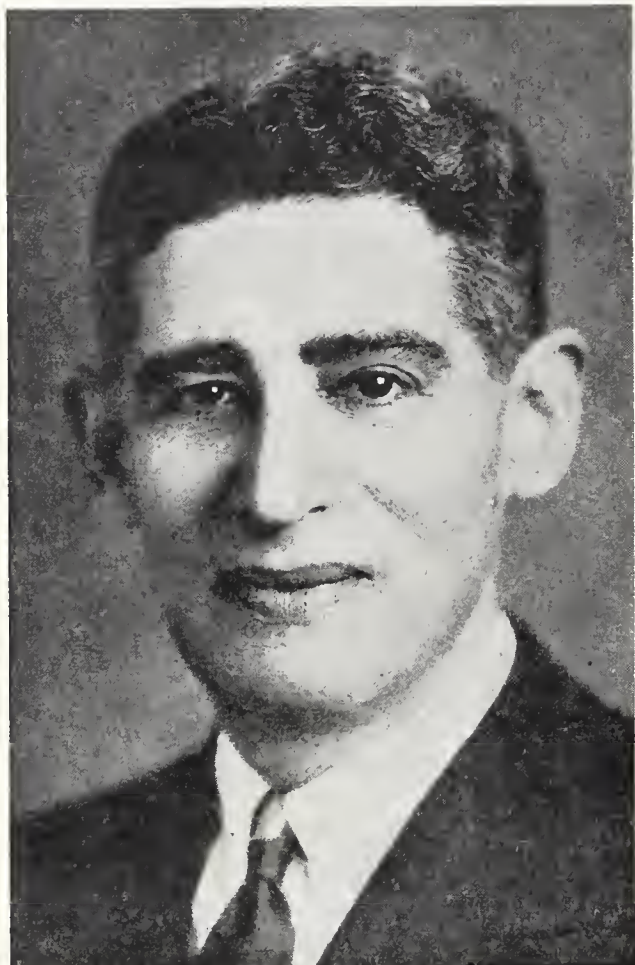
To the Editor:

Am in * * * now, so please change address "per se." The cleanliness, culture, religiousness and honesty of these people amaze me. They are so American, too. Have met several priests, doctors, pharmacists, and even a chiropractor! Sure seems good to see a little civilization again. Although, among the poor people, there is a little lack of modesty regarding a couple of natural body functions. More later.

As ever,

John J. Monfort, Capt., M. C.

OBITUARY



SIDNEY J. WOLFERMAN

SIDNEY J. WOLFERMAN, age 56 years, died at his home in Fort Smith February 18th. Born in Streator, Illinois, he attended the schools of that city and received his B. A. degree from the University of Wisconsin and graduated from Northwestern University School of Medicine in 1911. His internship was spent at Saint Louis City Hospital and he began practice at Fort Smith in 1914. During World War I he served in the army medical corps. He was one of the organizers of the Cooper Clinic at Fort Smith in 1920 and had been connected with that organization since its establishment. He had held all the offices in the Sebastian County Medical Society, was a Councilor of the Arkansas Medical Society from 1932 to 1938, serving as chairman of the Council in 1936-37; was President of the Arkansas Medical Society in 1938-39 and became a delegate to the American Medical Association in 1944. He served as Councilor from Arkansas to the Southern Medical Association from 1939 to 1944. He was a fellow of the

American Medical Association and of the American College of Surgeons. His civic interests were extensive and included member and past-president of the Fort Smith Rotary Club; director of the Hospital for Crippled Adults, Memphis; member of all the Masonic bodies, the American Legion, the Order of the Carabo, Military Surgeons' Association, Elks Lodge, director of the Arkansas Tuberculosis Association, director and past-president of the Sebastian County Tuberculosis Association; past-president of the Sebastian County Crippled Children's Society and many other interests. Surviving relatives are his wife, two daughters, two brothers, a sister and his mother.

FERGUS O. MAHONY, age 65, died at his home in El Dorado February 6th after an illness of a year. Born in El Dorado, he graduated from Tulane University in 1908 and returned to Union County where he was first associated with Dr. R. E. Rowland in practice at Huttig, moving to El Dorado in 1914 where he was associated with Dr. R. A. Hilton until the latter's death in 1916. Active in organized medicine he had served in the various offices of the Union County Medical



FERGUS O. MAHONY

Society and was President of the Arkansas Medical Society in 1934-35 and alternate delegate from the Society to the American Medical Association in 1936-37. He also served one term as Councilor from the fifth district. He was a fellow of the American Medical Association and of the American College of Physicians and a diplomat of the American Board of Internal Medicine. He was chief of staff of the Warner-Brown Hospital and had served as city and county health officer for the past twenty years. He was a member of the various Masonic bodies and of the Presbyterian church. Surviving are his wife, a daughter and two sons.

EDMOND WALLACE WOOD, age 79 years, died at his home in Marshall after an illness which forced him to retire from active practice in 1940. A graduate of Hospital Medical College, Louisville, in 1904, he had practiced in Searcy county since graduation. For a number of years he operated a drug store. Surviving are his wife, one son and five daughters.

MRS. HELEN WOOD LANIER, wife of Dr. L. H. Lanier, died January 23, 1945.

Mrs. Lanier was born at Milbank, S. D., went to school in Minnesota, moved to San Antonio with her father, who later moved to California. She was married to Dr. Lanier May 19, 1919, and since that time she lived in Texarkana.

Throughout her residence here, Mrs. Lanier was prominently identified with civic and club work. She was a charter member of the Current Topics Club, and served on the board of the public library. She was an active member of the Bowie-Miller Medical Auxiliary from the time of its organization more than 20 years ago, serving in all the offices of the organization, including the presidency. Until she became ill, Mrs. Lanier was a member of the Gateway Garden Club. She was a member of the Fidelis Matrons' Class of the Beech Street Baptist church.

Besides her husband, survivors are three sisters, Mrs. Clyde C. Bowe, Mrs. Marion La Salle and Mrs. Roamond Watters, all of Los Angeles, and three brothers, Dr. Guy L. Wood, Rockford, Ill.; Ray Wood, Bend, Ore., and Hugh J. Wood, Los Angeles.

COMMUNIQUE

January 10, 1945.

To the Editor:

Landed here on the 30th of November and

things were a little rough, but once all of our equipment arrived we have been living a little better even though we occasionally spend a little time in the foxholes. No bombs have been dropped in our immediate vicinity but we have seen the ships in the harbor bombed often, especially the first part of December. You should see the ack-ack the ships throw up. Looks like an old-time Fourth of July celebration and those boys can really shoot accurately. Many nights they would knock down all of the attacking Jap planes.

So far haven't met any Arkansas men over here but have asked about Sisco and several of the other fellows. I know they are over here somewhere but understand they are still in the ** theater. Guess they will move up for the big show that is now in progress. Think my outfit will move up before too long and we should see a little excitement.

I have received two copies of Random Thots and really enjoyed them. Will keep you posted on the people from home I meet over here and if you know of any in this immediate theater, please inform me. I will certainly look them up and give them all the dope I know about the States since I left there only two months ago. Thanks again for Random Thots and best wishes to you.

Faternally yours,

Elmer J. Ritchie, Maj., M. C.

COMMUNIQUE

December 8, 1944.

To the Editor:

Well, this is the first time I have been located where I could write you for about six months. Strangely enough, some of the "Random Thots" and the copies of The Journal did finally reach me, even on the **, and I really enjoyed reading them. It was the only contact I had with medicine or with the boys from Arkansas.

I am now stationed at ** but I don't expect to be here long. I am hoping to be back in the States during the holidays. None of the medics here in ** are from Arkansas, but one is enough. I can vouch to all of you that you haven't missed a great deal by not coming here.

I got my captaincy November 15th and was glad to read in The Journal that many of my friends had also gotten theirs.

One thing that is being discussed a lot here among the doctors and argued about is the status of the plans that are being presented in the States concerning socialized medicine. Everybody is hazy on the exact plans, etc., but they are definitely against them and feel that entirely

too little is being done by the doctors at home to try to hold off the apparent trend in the direction.

Since there is very little to write, and since I am hoping to be back in Arkansas soon, I'll close.

Sincerely,

Huie Haskell Smith, Capt., M. C.

WHAT EVERY WOMAN DOESN'T KNOW— HOW TO GIVE COD LIVER OIL

What every woman doesn't know is that psychology is more important than flavoring in persuading children to take cod liver oil. Some mothers fail to realize, so great is their own distaste for cod liver oil, that most babies will not only take the oil if properly given, but will actually enjoy it. Proof of this is seen in orphanages and pediatric hospitals where cod liver oil is administered as a food in a matter of fact manner, with the result that refusals are rarely encountered.

The mother who wrinkles her nose and "makes a face" of disgust as she measures out cod liver oil is almost certain to set the pattern for similar behavior on the part of her baby.

Most babies can be taught to take the pure oil if, as Eliot points out, the mother looks on it with favor and no unpleasant associations are attached to it. If the mother herself takes some of the oil, the child is further encouraged.

The dose of cod liver oil may be followed by orange juice, but if administered at an early age, usually no vehicle is required. The oil should not be mixed with the milk or the cereal feeding unless allowance is made for the oil which clings to the bottle or the bowl.

On account of its higher potency in Vitamins A and D, Mead's Cod Liver Oil Fortified With Percomorph Liver Oil may be given in one-third the ordinary cod liver oil dosage, and is particularly desirable in cases of fat intolerance.

COMMUNIQUE

United States Military Academy
West Point, New York,
January 23, 1945

To the Editor:

I have just received my Journal and thank you for it. However, since my last note to you, I have been permanently (?) assigned here. I have a very interesting job here but I wonder sometimes how close it is to war. Yet as long as someone must do it I feel that I have the qualifications for the work and I like it very much.

I am the physician for all the athletic teams

here. I also hold Cadet sick call each morning. We now have athletic squads totaling about 625 men. We have good physical medicine equipment. I am allowed to travel with any of the teams except football when I must be with them at all times. It is like awakening from a dream to find that it is true.

I enjoy reading The Journal and your Random Thots. I am especially interested in the communications from the various men I know. I hope that some day we can all get together and listen to the real experiences that some of the men have had.

My kindest regards to my friends.

Sincerely,

Robert W. Boyle,

Capt., M. C.

COMMUNIQUE

January 9, 1945.

To the Editor:

I had long since intended to drop you a line for I know it must be a job keeping tab on all of us medics from Arkansas.

I have been on duty in this area for some twenty months, the last two here in the **, the rest at points north.

I haven't seen many of the boys from home during this time, only Jimmy Lewis and Ed Dunaway.

The Journal was always welcome out there. Please send it to me at the address on the envelope.

Very truly yours,

Neil Compton, Lt., M. C., USNR.



COMMUNIQUE

31 January 1945

To the Editor:

I think the readers of The Journal will be interested to hear that Captain Vincent E. Mazzanti, formerly of Like Village, and a very popular student at the University and intern at St. Vincents, 1941-42, is here as a patient. He was wounded in the Western Pacific sustaining gunshot fractures of the lower extremity, particularly the cuboid of the right foot. It is plenty bad though he is up in a walking cast and I think will eventually have a practically normal foot. However, it will be some time.

If you do not know Mazzanti you are not familiar with his fine sense of humor. He wrote me a letter from overseas in which I think he tells more than is proper for publication. He had quite a number of experiences and close shaves before being 'nipped.' His final summary of the situation is that it is quite dangerous over in that country.

We are extremely busy here particularly with amputations and neurosurgery.

Best regards,

Henry G. Hollenberg,
Colonel, Medical Corps,
Chief of Surgical Service,
Bushnell General Hospital,
Brigham City, Utah.

COMMUNIQUE

January 12, 1945

To the Editor:

Thanks for the good work in The Journal and in Random Thots. I read them more than I did while I was in Texarkana.

Can you tell me the whereabouts of J. W. Sneed who was at one time in Searcy and of E. J. Ritchie, formerly of Little Rock, both in U. S. Army? I interned with them one year down in San Antonio. I'd also like to have J. W. Burnett's address if you have access to it; he was in Texarkana.

I am with the University of Illinois unit. That's my alma mater and we followed the * * * Army in Italy and now * * * Army through France. I've been in * * * but just on a short visit.

We have no evidence that Jerry is about to fold up. Wish it was true. At one time, we started to sweat out a trip to the Pacific but maybe they'd better sweat out a trip over here.

My mail from you is still forwarded from Texarkana. How about changing to * * *.

Karlton Kemp,
Captain, M. C.

COMMUNIQUE

January 19, 1945

To the Editor:

I received my December edition of "Random Thots" today. As I noticed you were still sending it to my old APO, I decided I had better write. My new APO is * * *. I'm still in the same outfit otherwise, and we are in the same spot as when we first hit * * *.

I haven't run across any more Arkansas docs, but as we are more or less isolated, I don't leave the hospital so very much.

The weather is really cold over here at the present; however, the Germans haven't noticed it as the Russians are making things hot for them.

Sincerely,

Gordon Holt,
Lt., M. C.

WOMEN'S AUXILIARY NEWS

Woman's Auxiliary to the Bowie-Miller Medical Societies held its regular meeting January 26th at the home of Mrs. Reavis Pickett, with Mrs. William Hibbitts as the chief speaker. Mrs. Hibbitts made an interesting talk on "Medicine in World War II."

The speaker told many interesting facts about the improvement in medical treatment of soldiers in the present war over that of the First World War. She brought out the fact that doctors worked closer to the battle lines than ever before, performing many operations now on the battlefield, which have never before been performed right on the front lines.

The fact that soldiers are now furnished with medical kits which contain blood plasma, sulfanilamide tablets, and other medicines was brought out, many lives having been saved by this treatment by the soldiers themselves. Blood transfusions are now given by doctors on the battlefields and treatment given for shock and other causes of death following battle wounds.

The fact that the Russian army is far ahead of other armies in physical fitness was brought out by Mrs. Hibbitts, who said that this was due to compulsory physical check-ups and hospitalization in Russia and also to the fact that Russia was said to be entirely free of venereal disease.

Mrs. Hibbitts also praised the work of dentists, nurses, and hospital aids in the present war and the work of veterinarians in sections where animals are still used in warfare.

Mrs. Allen Collom read an interesting letter from her husband, Maj. Allen Collom, who is serving in a general hospital in the European



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theater of war. The large number of patients being treated in this hospital and the number of operations performed was amazing to the women present, according to club officers.

Mrs. Ralph Cross gave a comprehensive talk on "Amputations," telling of amputations now being performed on the battlefields successfully, saving many lives in the various war theaters.

A social hour followed, when members were served from a table decorated with pink camellias. The home was decorated attractively with camellias and potted primroses, and other flowers.

Mrs. R. R. Kirkpatrick poured coffee and attractive refreshments were served by the hostesses, Mrs. Hibbitts, Mrs. Reavis, and Mrs. Karlton Kemp. Mrs. McCarroll, of Dallas, sister of Mrs. Kittrell, was a visitor.

Mrs. Kirkpatrick directed the business session in the absence of Mrs. J. T. Robinson. Minutes were read by Mrs. Harry Murry, secretary. Mrs. John H. Rives gave the treasurer's report.

Mrs. Charles T. Chamberlain was hostess for the February luncheon meeting of the Auxiliary of the Sebastian County Medical Society February 12th. Luncheon was served at 12:30 o'clock. Mrs. B. L. Ware, president, presided at a routine

business session. Mrs. Martin M. Even was enrolled as a new member.

At the conclusion of the business session, Mrs. Ware turned the meeting over to the program chairman, Mrs. J. J. S. Southard, who presented the guest speaker, Mrs. G. E. Frederickson, who spoke on "Nutrition and its Relation to Public Health in Sebastian County."

Members present were Mrs. B. L. Ware, Mrs. W. R. Brooksher, Jr., Mrs. W. L. Shippey, Mrs. Walter G. Eberle, Mrs. J. S. Southard, Mrs. Davis W. Goldstein, Mrs. Martin M. Even, Mrs. Charles T. Chamberlain, Mrs. W. F. Rose and Mrs. C. W. Hall of Greenwood.

Mrs. W. F. Rose,
Publicity Chairman Sebastian
County Medical Society Auxiliary

BOOK REVIEW

Medical Uses of Soap. Edited by Morris Fishbein, M. D. Pp. 182. Price \$3.00. Philadelphia: J. B. Lippincott Company, 1945.

This volume comprises articles on the medical uses of soap. Among the subjects presented are the usual and the unusual effects of soap on the "normal" and on the diseased skin, the effects of soap on the hair, soaps for industrial uses and soap for shaving. The authors have previously written articles on these subjects and many questions on the effects of soap will be found answered.

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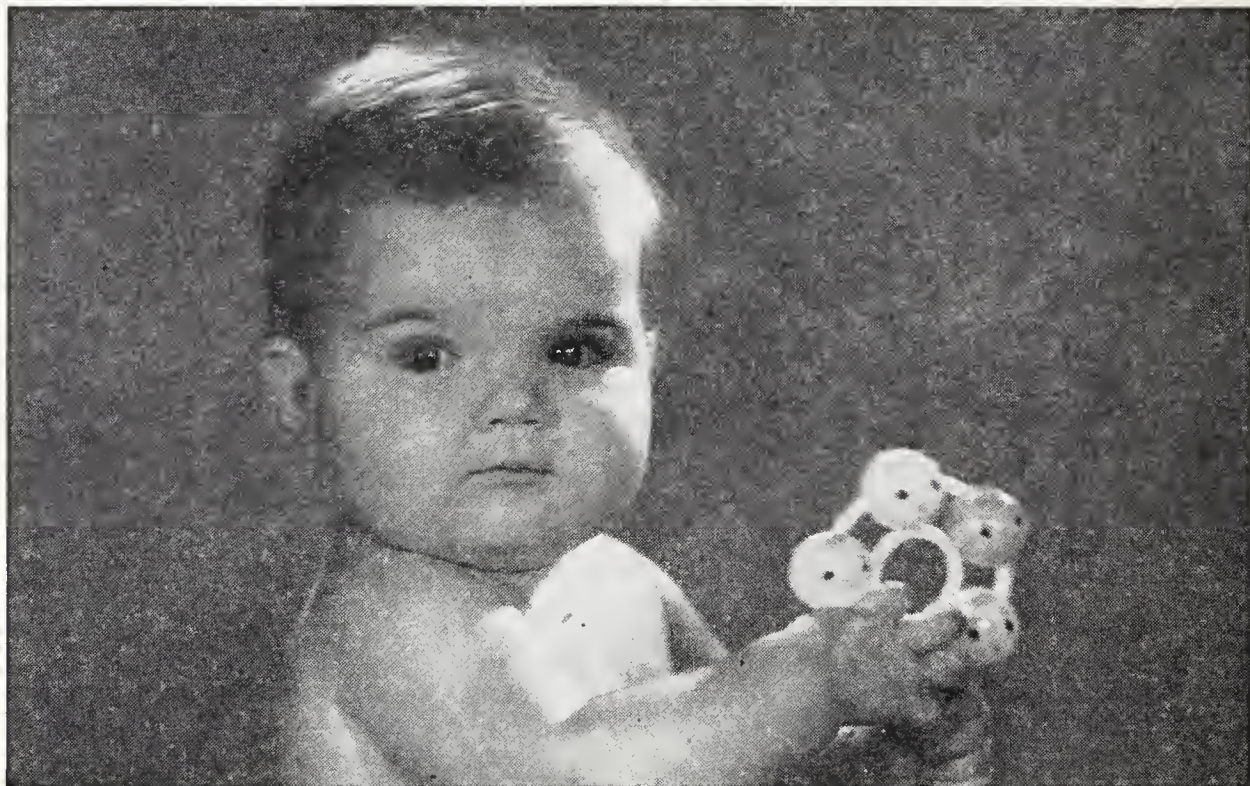
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The Journal of the Arkansas Medical Society

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CANCER CONTROL, A DOCTOR'S PROGRAM*

EDMUND G. ZIMMERER, M. D.
Des Moines, Iowa

The increasing mass of cancer propaganda that reaches his desk, some of it promulgated by non-medical groups, makes the doctor increasingly conscious of the popular interest in cancer and its control. He notes the concern of governmental agencies and even professional societies in the establishment of tumor clinics and is aware of the endorsement given such activities by organized medicine. Perhaps he is invited to participate in the work of tumor clinics, at least to the extent of referring his patients. He patiently endures the lay campaigns in which his name appears as sponsor. He may even be asked to speak at cancer meetings, often under lay auspices, and he may occasionally be embarrassed at sharing the platform with a glib lay speaker whose eloquence seems to put his own knowledge of the subject to shame. No wonder he sometimes asks himself where this will lead.

The need for state control of communicable disease has long been conceded. The official supervision of motherhood and of infancy, as in the EMIC program of the Children's Bureau, and even of the child of school age is accepted with more or less reluctance. The treatment of the venereal diseases under public auspices is acknowledged as the best means of controlling their infectiousness and preventing their spread. But the entry of public health into a field which deals with a condition not proven infectious and definitely shown to be noncommunicable, in which the incidence has been little influenced by treatment, seems to portend a ruthless invasion by the state into the whole realm of medical practice from pediatrics to geriatrics.

The program of cancer control was not originated by public health authorities, governmental agencies, or any professional group, but has evolved from a popular demand. It did not arise because of any revolutionary discoveries in either the prophylaxis or treatment of cancer, or even of any definite knowledge as to its underlying causes. It is the outgrowth of fear caused by the increasing incidence of cancer. When any condition rises in a quarter of a century from fifth to second place among the leading causes of death, it obviously becomes a matter of public concern.

Congress, in the first bill in history to be sponsored by the entire body of the United States Senate, took official cognizance of the popular sentiment in 1937 when it appropriated funds for the National Cancer Institute. The American Society for the Control of Cancer, now known as the American Cancer Society, Inc., was organized in 1901. At first it was a purely professional society whose membership included many leading physicians and pathologists. Later it enlisted interested laymen and more recently has extended its activities by establishing a Field Army which has undertaken a widespread program of lay education, always in cooperation with medical societies.

The first public health recognition of the cancer problem was in 1925 when a lay group headed by a prominent Catholic clergyman succeeded in securing an appropriation from the General Court of Massachusetts for the care of cancer patients. Thanks to the farsightedness of Dr. George Bigelow, part of these funds was used for the study of the preventive aspects of malignancy. Thus, Massachusetts became the first state to establish a program of cancer control. To date nine states have full-time personnel engaged in this work, and all health departments are giving cancer control more or less attention.

Hence, we behold an almost ideal setup for the solution of any public health problem. We have a widespread public interest, with press, pulpit, school, and every avenue of education willing and ready to do its part, a government anxious to give such aid as it can, state health

* Reprinted by permission from the Journal of the Iowa State Medical Society, February, 1945.

¹ E. W. Rowe, Better Health, Nebraska State Department of Health.

² Louis I. Dublin, Metropolitan Life Insurance Company, Letter of November 7, 1943.

³ Connecticut State Department of Health.

departments everywhere giving it more and more attention, countless researchers aided by public and private funds carrying on intensive study in cancer genesis. All these, money, legislation, and organization, are helpless to accomplish anything without the willing cooperation and leadership of the doctors in the hospital, in the city, in the rural home, everywhere.

Obviously a completely satisfactory control program must await at least the discovery of the cause of cancer or a more thorough understanding of its nature, if not a specific remedy or some practical prophylaxis. Physicians would be the first to recognize that we cannot wait till we know all about a disease to do something about it, that we must use available means and knowledge to the best of our ability.

Early and accurate diagnosis and prompt and adequate treatment are the keynote of our present program of control. Early diagnosis implies that the patient comes early to the physician and that the physician be qualified to act without delay. To that end it must be universally recognized by the public that cancer begins as a local disease and that while it is in that stage it is generally curable. We must strive to make all people alert to the early signs of malignancy and prompt in seeking competent medical aid. Here lay education is our most important available means. Such education must be neither technical nor detailed. It must be simple, easily understood, and above all, motivating. The facts about cancer must be disseminated in the school and home, in the family, and in social circles to be effective. Lay organization is of the greatest assistance in giving us an entree to the very people most in need of education.

True, there are disadvantages to campaigns by unofficial and particularly lay organizations aside from their frequent lack of dignity, but their practical value has been amply demonstrated in the fight against tuberculosis, venereal disease, and infantile paralysis. Whether we like it or not, lay education in health matters seems best accomplished by campaigns, with ballyhoo, posters, buttons, exhibits, and distribution of literature. Such programs can be better carried out under lay than professional auspices, but must be restrained and directed by ethical and experienced leadership.

The widespread interest and the alarm created by misrepresentation and ignorance of the truth about cancer offer a fertile field to the charlatan and the quack which can be combatted only by a unified and authoritative program of education. Education implies a general dissemination of

knowledge based on accurate conclusions drawn from known facts. In cancer, as in other diseases, this involves statistical evaluation of a significant universe such as is more readily accessible to a public health department than any other agency.

Constant research and new discoveries contribute ever changing views as to the nature of malignancy, which must be quickly and carefully sifted to prevent the too ready acceptance of promised cures and yet make prompt use of these means which have merit for the suffering public. Only a centralized authoritative body close to organized medicine, the research laboratory, the hospital, and the clinician, and one which enjoys the confidence of the physicians and the public alike, can coordinate the conflicting trends of thought to avoid inconsistency. Only such a body can control and direct lay activity in health matters and coordinate them to professional guidance.

The function of the health department, then, continues to be that of correlator and liaison between the public and the physician. Its objectives cannot be attained without the confidence and cooperation of all agencies concerned, and least of all without the good will and active support of the doctor. Indeed, "the doctor is an integral part of the plan of public health administration just as the lawyer is part of his court."

We cannot shut our ears to the cry of the public that something be done about cancer. The people have spoken and in a democracy "the people should have what they want, but they must be protected from exploitation. They should have a voice with their physicians in the administration of their health programs."¹¹ They need and desire medical leadership, and nothing is gained but much is lost by our refusal to give it.

In the program of cancer control the doctor is the key man. On his degree of suspicion, upon his ability to recognize precancerous or early lesions, upon his recommendations depend not only the success of the program but, more important, the life or death of the individual. The first doctor seen by the cancer patient has more to do with the ultimate outcome of the case than the surgeon, radiologist, specialist, or clinic. Such responsibility imposes the obligation of being informed and competent or at least willing to seek competent consultation.

Unfortunately, too many doctors still have an ingrained pessimism regarding cancer that is not justified by the facts, and which reacts to the detriment of their patients. Almost 40,000 five-year cures of definitely authentic cases of malignancy in the archives of the American College

of Surgeons attest the curability of some cancers. Optimism is an important corollary to cancer control.

Delay in the treatment of cancer is dangerous. If the delay is due to the patient's ignorance or fear, it is bad enough; but if it is due to the doctor's carelessness or incompetence, it is practically criminal. The doctor's attitude plays an important role. If he makes light of a lesion, the patient will not regard it seriously either, and if he is instructed to return for further examination at some indefinite time he will be apt to postpone or neglect action until it is too late.

On a statistical basis it may be presumed that one in every 133 patients seen by a physician in Iowa is a cancer patient.² That more cases are not diagnosed may be due to the low degree of suspicion on the part of the physician or to his indifference to preventive medicine. If he is consulted for a cut finger or a sprained ankle, he does not bother to question his patient about the apparent leukoplakia on his lip. In this age of specialization, we are drifting from the beneficial habits of the old family doctor. Preventive medicine not only redounds to the patient's advantage but is remunerative as well.

Temporization with lesions of skin cancer is a common cause of delay that can be attributed to doctors.³ Irregular uterine bleeding is too often charged to the menopause and the doctor is too reticent to make a speculum examination. Even more common is our ready acceptance of the patient's own diagnosis of piles and neglect to make a simple examination. In fact, most of our mistakes are due not so much to our inability to recognize signs as to our failure to look for and find them.

The educational program of the Field Army stresses the importance of periodic physical examinations, but unless such examinations are thorough they not only fail to discover early cancer and save life but serve to discourage the patient and discredit the whole program. A mere history, taking of blood pressure, a casual auscultation of the chest, and a urinalysis will not always reveal cancer or permit us to give the examinee a clean bill of health.

The following points in the examination of an individual for cancer are suggested as being essential:

Examination of the lips, tongue, cheeks, tonsils, and pharynx for persistent ulceration, especially in the presence of a history of hoarseness or persistent coughing. In the latter case, a roentgenogram of the chest may be needed.

Examination of the skin, of the face, body, and extremities for scaliness, bleeding warts, black moles, and unhealed scars.

Examination of every woman's breasts for lumps or bleeding nipples.

Examination of subcutaneous tissue for lumps on the arms, legs, or body.

Investigation of any symptoms of persistent indigestion or difficulty in swallowing and palpation of the abdomen.

Examination of lymphatic system for enlarged glands, especially in the neck, axilla, or groin.

Examination of the uterus for enlargement, laceration, bleeding or new growths; bimanual examination to determine condition of ovaries and tubes.

Examination of rectum, always important even in the absence of symptoms.

Examination of urine for blood.

Examination of bones and a roentgenogram of any bone that is the seat of pain.

Examination of blood.

Careful examination and a roentgenogram if indicated when the history or physical findings point to abnormality in any other organ or tissue.

Biopsy, while ordinarily not a difficult procedure, is one of utmost value in confirming the diagnosis but should not be rashly done. In general, it should be made on the advice of and in consultation with the pathologist.

The diagnosis and treatment of cancer are always of grave importance—too grave most times to depend on the judgment of a single individual no matter how competent he may be. No matter what the physician's professional qualifications, he cannot hope to recognize cancer in its every possible manifestation; and if he could, he would not be able to recommend appropriate treatment in every case. Thus, "Cancer has ceased," as Ewing says, "to be a one man job." Tumor clinics divide responsibility, make for earlier, more accurate, and definite decisions in diagnosis and treatment, and encourage better training in both the recognition and therapy of cancer. Tumor clinics may be established by county medical societies in cooperation with the State Department of Health. A subsequent article will deal with their organization, benefits and use. Thus far, four are active in Iowa.

Reference to a tumor clinic does not exclude the patient's own physician. On the contrary, it enhances his position. No patients are accepted unless referred by a physician. The personnel of the clinic is selected by the local medical society. The referring physician is invited to participate in the examination and discussion of the case. All reports and treatment recommendations are made to him and he alone determines whether they shall be carried out, and where and by whom.

The minimum obligation of the individual physician to the program of cancer control is that imposed by his professional responsibility and common humanity, to make himself competent. He must be suspicious of malignancy in every

obscure case. He should be alert to the earliest, even precancerous manifestations of the disease. He should have available laboratory, X-ray, and other diagnostic facilities and be ready to seek competent consultation. And withal he should develop a reasonable optimism regarding the outcome of cancer therapy.

As a group, the profession can contribute to the training of its members. Cancer therapy, despite the fact that we still do not know all about the disease, is not static. Amazing advances have been made in recent years, especially in cancer of the breast, uterus, mouth, and buccal cavity. The medical society should have an active cancer committee whose function it is to bring modern thought on the subject before the society by means of frequent papers, symposia, and the like. It might well consider the establishment and maintenance of a tumor clinic. One of the principal benefits of the clinic is its professional training. Doctors should be encouraged to attend its clinical sessions, and frequent clinicopathologic conferences should be held.

The committee could develop higher standards of service in the community by urging more thorough examinations of potential malignancies, emphasizing the important steps in a complete physical examination, pointing out the value and dangers of biopsy, securing better records so that treatment methods can be better evaluated. A precise history and definite diagnosis are indicative of the quality of professional care the cancer patient is receiving. The same committee might well check on unorthodox treatment or unauthorized practice in the community.

If the doctors or the medical society desire to extend their activities beyond the range of purely professional interest, they might properly consider the arranging of lay meetings for the extension of health education to the public and co-operation with interested agencies. Professional activity is lagging far behind public interest in cancer. Apathy, jealousy, or personal prejudice must not blind us to the prevailing trends in preventive medicine. The doctor's place in this as in every program to fight disease and promote health is in the forefront. His leadership is desired and welcomed. The public and the state recognize their dependence on the doctor; without him there can be no effective progress in any health activity.

The program of cancer control, borne of need and of fear, is no exception. The program is not state medicine. It is not a lay object. It is and must be and always shall be the doctor's program.

STATE BOARD OF HEALTH TO MAKE MEASLES MODIFIER (Immune Serum Globulin) AVAILABLE

Immune serum globulin (gamma globulin) for the prophylaxis, modification, and treatment of measles will be made available to physicians and hospitals by the State Board of Health beginning early in April, it is announced by Dr. T. T. Ross, State Health Officer. It will be distributed without charge with the understanding that it will be administered in accordance with established standards and without any charge to the patient for the globulin.

This product is obtained from blood donated by volunteers through the American Red Cross for the armed forces. It is a by-product of serum albumin and is provided by the American Red Cross for civilian use without charge. The cost of processing, testing, and packaging was paid by the American Red Cross. The sale of this material is prohibited.

The immune globulin may be obtained through local health departments. In counties where there are no health personnel on duty it may be obtained directly from the State Health Department.

Normal Serum Gamma Globulin Antibodies (Human) Concentrated (Immune Serum Globulin)*

1. What is this material?

This preparation is a concentrate containing the antibody globulins derived from pooled normal human plasma collected by the American Red Cross.

2. What is its potency?

Preparations of Gamma Globulin Antibodies are standardized so that the concentration of antibody is 25 times that of the plasma pool from which it came. Since each pool is obtained from several thousand donors, variations in titer of measles antibody should be slight. Each preparation is tested for potency in the laboratory by tests for antibodies which can be readily measured. Whenever possible its potency is checked in a series of patients exposed to measles before release for general use.

3. Stability.

This material should be kept in the icebox like other biologicals. The dating period at present is set at one year. It is probable

* Prepared by C. A. Janeway, M. D., Harvard Medical School, Department of Pediatrics, for distribution by the American Red Cross.

that it will retain its potency for longer periods of time.

4. Indications.

At present this material is realized only for the prevention and modification of measles by passive immunization. Other possible uses are being studied, but insufficient data are available to evaluate its efficacy in these circumstances. Its use in the treatment of measles or the treatment or prophylaxis of other childhood diseases is not recommended at present.

5. Administration and dosage.

This material may be administered when indicated to patients who have had a definite exposure to measles in the infectious stage. Its use to prevent or to modify the disease is at the discretion of the physician.

For prevention—A dose of .08-0.1 cc./lb. body weight should be given as soon after exposure as possible, but will be fairly effective in the first seven days.

For modification—A dose of .02-.025 cc./lb. body weight should be given on or about the fifth day after first definite exposure.

Method of administration—The globulin is injected **intramuscularly**, preferably in the buttocks. For this, a 20- or 21-gauge needle is most satisfactory. Pull back on plunger of syringe before injection to be sure needle is not in vein, **since globulin as now prepared must not be used intravenously**.

Caution—The globulin is a concentrated protein solution, hence viscous and sticky. Do not fill syringe until prepared to make injection, otherwise syringe may become frozen.

Jaundice—Blood, plasma, and serum have been found on occasion to contain a jaundice-producing agent. Therefore, it is possible that fractions derived from plasma may contain a similar agent. Such jaundice appears 2-6 months after injection. No jaundice has been attributed to this material so far, but careful records of its use should be kept so that any cases of jaundice occurring 2-6 months after injection may be traced to the particular lot concerned.

6. Safety.

A great many **intramuscular** injections have been given without any serious reactions and with very little local pain in the dosage recommended. Rarely, fever, irritability, or ten-

derness of the site may follow injection in the first 24 hours.

7. Duration of effect.

A single dose will probably protect a child for about three weeks. At the end of that time, if the child is re-exposed and protection is desired, the dose should be repeated.

8. Results of injection.

With any biological system, in which the virulence of the virus and the resistance of the host may vary considerably, some variation in results is to be expected. With the small doses used for modification, a few patients will develop typical measles; with the large dose, used for prevention, a certain number will fail to develop any evidence of measles.

Mild measles which results from a satisfactory modification may vary from a disease only slightly milder than the average case to one that exhibits only one or two of the stigmata of measles. Malaise and fever are usually markedly reduced, the catarrhal symptoms slight, and rash may be evanescent and sparse.

COMMUNIQUE

March 16, 1945.

To the Editor:

Your February 17th V-mail arrived today. Am snatching an answer hurriedly as we are so darn busy I'm even losing weight. By night I make three tracks, one for each foot, the other for my fanny. We are really close to war now! With soldiers, guerrillas and civilians, we are over twice our normal strength, with the same personnel.

I know you have heard it before, but I want to say it again, briefly, you have no idea of the value of the whole "O" type blood, flown here daily, and of penicillin. They make so much difference! For example, recently we had an amputation, thigh, to do, result of flak. Patient received four thousand ccs. of blood in the operating room and another 500 cc. the next day. Temperature never went beyond 99.6, thanks to penicillin. The penicillin makes skin-grafting do much more beautifully than before.

Received a December Journal and sure appreciated it.

Best wishes and regards,

John J. Monfort, Capt., M. C.

MODERN CONCEPTS OF CARDIOVASCULAR DISEASE

COMMITTEE ON THE HEART, ARKANSAS
MEDICAL SOCIETY

C. T. CHAMBERLAIN, M.D.
Chairman, Fort Smith

Here follows the third of a series of summaries on the subject of hypertension. This presentation by Reginald H. Smithwick of Boston has to do with hypertension from the standpoint of surgical therapy.

"The surgical treatment of hypertension is a comparatively recent addition to our medical armamentarium. Aside from unilateral nephrectomy, which almost always fails to modify the hypertensive state, and the removal of adrenal tumors, medullary or cortical, (rare causes of hypertension) surgery has consisted largely in removing portions of the sympathetic nervous system, particularly those having to do with the vasomotor control of the vascular supply of the viscera of the splanchnic bed. The purpose is to lower blood pressure by decreasing the tone of arteriolar smooth muscle. Surgical technique has varied according to the author, Adson, Craig, Peet, Crile, Smithwick, and Grimson. The difference lies largely in the extent of these operations. This has varied from partial to total or near total denervation of the splanchnic bed; to total or near total sympathectomy. In general, it seems as if the more extensive operations have been more effective, although time may show that increasing the operation beyond a certain point may yield diminishing returns which may not compensate for an increase in untoward symptoms resulting from the attendant physiological changes.

It has been demonstrated beyond a doubt, that in a significant percentage of patients with continued diastolic hypertension persistent lowering of blood pressure has resulted from surgical intervention of this sort. This has been associated with favorable changes in the eyegrounds, electrocardiograms, and cardiac and renal function as measured by ordinary tests as well as symptoms. It seems reasonable to conclude that the sympathetic nervous system play a role in the mediation of increased peripheral resistance to blood flow in many hypertensive patients. This may be regarded as a modern concept. Recent data bearing upon the clinical aspects of the surgical treatment have been published and will not be discussed further in this communication.

Other concepts have emphasized vascular dis-

ease and humoral pressor substances as important factors in the causation of hypertension in man. The surgical approach to hypertension has offered the first opportunity to obtain direct information concerning the state of the arterioles, particularly those in the renal area, in living hypertensive patients. The kidneys have been inspected and biopsies for microscopic study taken at the time of lumbodorsal splanchnicectomy. Previously, the only methods of evaluating vascular disease directly were the gross and microscopic study of autopsy material, which had disclosed that the kidneys of hypertensive patients show comparatively more evidence of damage than do other organs and tissues. This has led many to believe that renal arteriolar disease therefore antedated and in some way was the real cause of most cases of chronic hypertension in man. Others, undoubtedly the minority, have felt that this was not necessarily the fact. The finding of severely damaged kidneys at death did not prove that this condition must have existed prior to the onset of hypertension. The biopsy material introduces data pertaining to the earlier stages of hypertension in man and favors the viewpoint that renal vascular disease does not necessarily antedate the hypertensive state.

It is interesting to review some of the evidence, chronologically, which bears upon the cause of hypertension since Bright first called attention to this matter in 1827. Bright observed that at death contracted kidneys were associated with hypertrophied hearts. He stated that the "two most ready solutions appear to be, either that the altered quality of the blood affords irregular and unwonted stimulus to the organ immediately, or, that it so affects the minute and capillary circulation, as to render greater action necessary to force the blood through the distant subdivisions of the vascular system." Thus, in this earliest concept, the cause was thought to be pre-existing renal disease and the effective mediator a circulating humoral substance.

This concept had as one of its most ardent supporters Johnson, who stated in 1872 that the most common causes of contracted kidneys "were excess of food stimulants, with or without decided gouty symptoms, but he had seen many cases in which the disease had been a result of chronic dyspepsia in persons of strictly temperate habits. The proximate cause of the renal degeneration was the excretion of abnormal products by the gland-cells." Once the kidneys had thus been rendered cachectic, the following events transpired, in consequence of the degeneration of the kidney the blood is morbidly

changes. It contains urinary excreta, and it is deficient of some of its own normal constituents. It is, therefore, more or less unsuited to nourish the tissues, more or less noxious to them. The minute arteries throughout the body resist the passage of this abnormal blood. The left ventricle, therefore, makes an increased effort to drive on the blood. The result of this antagonism of forces is that the muscular walls of the arteries and those of the left ventricle of the heart become simultaneously and to an equal degree hypertrophied. The persistent overaction of the muscular tissues, both cardiac and arterial, is registered after death in a conspicuous and unmistakable hypertrophy."

This concept was given great impetus by the brilliant experiments of Goldblatt during the past ten years, many times confirmed by others, who demonstrated that if the blood flow through the kidneys of dogs is significantly reduced by partial clamping of the renal arteries persistent hypertension invariably. Previously, Cash had been able to produce experimental hypertension by excising a considerable amount of renal tissue, a more difficult and less satisfactory experimental method. Subsequently, Page was able to produce chronic renal hypertension due to a constricting perinephritis, which resulted from wrapping cellophane or silk about the kidneys. Referring to his observations Goldblatt in 1940 stated, "the investigations to be described here were begun because it was thought that the problem of the possible renal origin of the type of hypertension that is associated with vascular disease of the kidney, with or without accompanying renal excretory insufficiency, should be capable of solution by experiments on animals. By postulating that if the vascular disease of the kidney be responsible for initiating the hypertension, it must precede the development of the hypertension, it became necessary in some way to reproduce the vascular disease in the kidney, or to develop some method whereby the probable functional disturbances of renal circulation caused by the vascular disease could be reproduced. The effect of such vascular disease, it was assumed would be renal ischemia, and it was thought, therefore, that a solution to the problem should be possible, if a method of the production of renal ischemia in animals could be developed. . . . It appears to be established beyond reasonable doubt that the hypertension which develops after constriction of the main renal arteries, or as a result of renal ischemia produced by any method, is due to some humoral mechanism of renal origin. Evidence is accumu-

lating to justify the conclusion that the results of these studies on animals may be directly applicable to the pathogenesis of both the benign and malignant phases of essential hypertension in man, which is associated with the presence of intrarenal or extrarenal vascular or other disease that can produce renal ischemia. Further knowledge of the pathogenesis and perhaps the treatment of this condition will depend upon the establishment of this conclusion."

The concept that primary renal arteriolar disease was the cause of hypertension was further supported by Moritz and Oldt, who studied the vascular changes in various organs and tissues of 100 normotensive individuals dying of various causes and 100 hypertensive patients dying of various complications of their disorders. Their study "disclosed only one situation in which the presence of arteriolar sclerosis was almost invariably associated with hypertension and where the absence of arteriolar sclerosis almost invariably betokened an absence of high blood pressure. This was in the kidneys." They felt that their findings "supported the conclusion that renal arteriolar sclerosis is the most common cause of chronic hypertension. This conclusion is in accord with the recent demonstration by Goldblatt that chronic hypertension is regularly produced in dogs and monkeys by reducing the blood flow through the kidneys (renal ischemia). The effect of the renal arteriolar sclerosis in human hypertension appears to be the functional analogue of the renal arterial clamp in experimental hypertension."

The renal humoral concept had received further support when Tigerstedt and Bergman identified a substance, renin, by observing the pressor action of crude kidney extracts. Since that time, particularly during the past ten years, a vast amount of work has been carried out by many investigators in an attempt to isolate the pressor substance which is thought by many to be responsible for experimental hypertension of the Goldblatt variety and for human hypertension as well. Particularly active, have been workers in Houssay's laboratory in Argentina and Page's laboratory in this country. The evidence which has so far accumulated has recently been reviewed in detail by Landis who notes "the failure of almost all observers to detect pressor activity when the blood from hypertensive animals and man or extractives of such blood have been injected in many different assay preparations." In spite of a large amount of indirect evidence favoring the humoral concept, direct proof of a pressor substance being the sole

mediator of chronic hypertension in man does not as yet exist. According to Landis, failure to demonstrate a pressor substance might be "that hypertensive, as soon as it is formed, immediately leaves the circulating blood to be attached at once to the smooth muscle of the blood vessels, and in so doing produces its constrictor effect."

The concept that hypertension resulted from by Gull and Sutton who made a detailed study of gross and microscopic changes in various organs and tissues of patients dying of chronic Bright's disease. As a result, they concluded "this theory does not appear to us supported by the facts." Among the facts they mention are: "(1) there is a diseased state characterized by hyaline-fibroid formation the arterioles and capillaries. (2) The kidneys may be but little if at all affected, whilst the morbid change is far advanced in other organs. (3) The contraction and atrophy of the kidney are but a part and parcel of the general morbid change. (4) It is probable that this morbid change commonly begins in the kidney, but there is evidence of its also beginning primarily in other organs. (5) In the present state of our knowledge we cannot refer the vascular changes to an antecedent change in the blood due to defective renal excretion. (6) The kidneys may undergo extreme degenerative changes without being attended by the cardio-vascular and other lesions characteristic of the condition shown as chronic Bright's disease."

Acknowledgment is hereby made of permission by the American Heart Association to publish the above.

WYETH ANNOUNCES NATIONAL DISTRIBUTION OF PENICILLIN; DEVELOPS PENICILLIN TABLET FOR ORAL DOSAGE

Wyeth Incorporated, Philadelphia, has announced that all of its warehouses are ready for national distribution of penicillin for civilian use when WPB lifts restrictions on March 15.

A new container called the **Vipule**, described as combining the features of the vial and ampule, has been developed by the company for guarding the potency of the penicillin so that it will remain stable for long periods of time.

"We are thus able to keep our branches stocked with sufficient inventories of penicillin over long periods without running the danger of deterioration," explained Mr. Howard. "Moreover, the **Vipule** method of packing furnishes a

sterile product that yields a 'laboratory fresh' solution of penicillin under all conditions at time of use. One **Vipule** contains 100,000 Oxford Units of penicillin, a second **Vipule** a sterile salt solution. An ingenious method of transferring the salt solution to the dry, porous penicillin, insures the preparation of a sterile penicillin solution without exposure. This is not possible when the syringe is used in the ordinary way," he said.

Mr. Howard also announced that a new Wyeth penicillin in tablet form, for administration by mouth, will be ready for national distribution as soon as the allocation of penicillin for oral use is released by WPB, which is expected soon. These are the first penicillin tablets to be manufactured for oral use, he said.

COMMUNIQUE

March 6, 1945

To the Editor:

This is just a belated note to thank you for sending me the news of Arkansas doctors. I always enjoy hearing of the "goings on," around home and abroad.

I am sure you know that Gaston Hebert has been shipped out. That leaves me the only Arkansas man on the staff here.

I am still enjoying this state-side duty. I don't know how much longer before I will be shipped out again.

Best regards to all the fellows.

Sincerely,

Joe B. Wharton, Lt., MC., USNR.,
Naval Hosp., San Diego, Calif.

COMMUNIQUE

March 3, 1945

To the Editor:

Enclosed you will find my book review, submitted with my usual degree of promptness, considering distance, three weeks' leave in Australia and tropical inertia. In fact you did ——— well to get it at all.

I also thought you would enjoy "The Short Course to Rotation" which has been furnished to us in preparation for state-side duty which we are hoping is not too many moons in the offing. Perhaps you have already seen a similar publication.

The Journal arrives regularly and the Communiques and Random Thoughts are enjoyed immensely, even though the latter has been classified as an "excrecence."

Sincerely,

Fred H. Krock,
Comdr., M.C., USNR.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

JOSEPH CONRAD once said, "A word carries far — very far — deals destruction through time as the bullets go flying through space." Medicine has a few such words. Too often these are used when a serious or potentially serious condition must be explained to an apprehensive patient. When words treacherously lull either the patient or the physician into a false sense of security, then words may ultimately maim or destroy as surely as if they were bullets.

A SPOT ON THE LUNG

It is futile to search in dictionaries or medical text-books for a definition of the term "a spot on the lung." But the term is being used with great frequency by physicians, nurses and laymen alike. If this term is subjected to scrutiny, it is found that it may mean anything and everything that produces either a shadow or an area of decreased density in a chest roentgenogram or anything and everything that causes abnormal physical signs over the lungs. If, then, this expression has no meaning that cannot be stated more precisely in other terms, it remains to be found out why it is being used. If this is one of the terms that does not express a definite meaning, does it possibly obscure a meaning?

Nobody who has searchingly studied the histories of patients with pulmonary disease can doubt that the real function of the phrase, "a spot on the lung," is to cloud the facts. It is a cloak for a great variety of pulmonary diseases, a protective screen for the inability or unwillingness of the physician to arrive at a diagnosis acceptable to himself, a disguise for a bitter truth that the physician hesitates to tell the patient, an escape for the patient who tries to elude further diagnostic work and necessary treatment. After all, one does not die of "a spot on the lung," but one can die of bronchial carcinoma and one might die of pulmonary tuberculosis. Along with much other evasive, medical double-talk, "a spot on the lung" is a verbal mechanism of escape from reality. In the same category belongs the term "a touch of tuberculosis" and, improperly applied, "nothing but a little thickened pleura."

No physician needs to be told that "a spot on the lung" is no diagnosis. He realizes that it is

evidence, on the one hand, of healed disease which calls neither for treatment nor for alarming its bearer, or, on the other, of active disease in need of treatment. The physician sometimes uses the term in patients in whom he has failed to establish, with a certainty that carries conviction for himself, the difference between active disease and obsolete scar. "A spot on the lung" has a pleasantly innocent sound. It lulls into inertia and indifference whatever doubts or curiosity the patient, and, even in some cases, the doctor may have. But still it is, for the physician, a mental reservation. It seems to beckon as a safe place to stand if "as a spot on the lung" later turns out to be carcinoma, tuberculosis or bronchiectasis.

Admittedly, this judgment may be harsh. But I dare say that it will be resented only by those who, with the instrumentality of this ambiguous term, neglect their obligation of persevering until "a spot on the lung" has been accurately diagnosed. No person need be told that he has "a spot on the lung." If the condition is as clinically insignificant as the term suggests, the patient should be told that he has a scar from a previous tuberculous infection—one that needs an occasional check-up or one that needs no further observation. Or when the diagnosis is certain, the patient should be told that his lungs are normal. For, while "a spot on the lung" is often the obscured beginnings of destructive disease, it is, in other cases, the starting point for tuberculo-phobia and anxiety neuroses, conditions that are no less crippling and hardly more easily curable than tuberculosis itself.

But, though every reflecting physician knows that "a spot on the lung" is a meaningless and

dangerous term, the utter convenience of the expression—and others like it—mitigates against their prompt extinction. Past experience justifies a pessimistic outlook. No amount and intensity of medical education are likely to eliminate entirely the term from medical parlance. Medical education, however, is being overtaken by the information that the public, including the prospective patient, is acquiring. People are learning to realize fully the confusing ambiguity of the term, they are beginning to refuse its acceptance just as an enlightened consumer protests against ambiguous and misleading labels on packaged goods. And the comparison is eminently proper: for all intents and purposes, "a spot on the lung" is ambiguous and misleading labeling. It may well be that through the protest of the consumer, by the refusal of every layman to be satisfied with the pseudo-diagnosis of "a spot on the lung" the term will eventually disappear.

It is high time for the medical and nursing professions and everyone engaged in tuberculosis work to bury a medical term that has quite literally buried so many patients.

A Spot on the Lung, Max Pinner, M.D., The NTA Bulletin, January, 1945.

UPJOHN MESSAGE URGES EARLY DIAGNOSIS OF CANCER

Spurred by a rising rate of 165,000 deaths, and 700,000 sufferers annually, Upjohn is assisting in the fight against cancer. With a message of hope which will reach millions during April when the American Cancer Committee's national drive swings into action, Upjohn includes this major health problem in its "Your Doctor Speaks" series directed toward better public health and greater patient-physician cooperation. Since the greatest promise of reduction in cancer mortality lies in early diagnosis and treatment, the new Upjohn message stresses the importance of learning to "recognize warning signs of cancer **before** it's too late," and bluntly tells the reader, "**You** can help—by learning to suspect cancer and to report it at once."

A Message of Hope

Number five in a new series, the Upjohn cancer message, scheduled to appear in Saturday Evening Post, April 7; Time, April 16; and Hygeia, May, brings hope to millions of readers right from the headline—"You'd never guess he had a cancer five years ago." Beneath the figure

of a distinguished middle-aged man painted in full color by a nationally famous artist, the message reads: "Yes, he's only one of the 90,000 who could be saved every year if cancer were reported in time. Today radium, X-ray, and surgery make it possible to control 70% to 80% of early cancer, and about 39,000 cures have been officially recorded."

"Go to Your Physician"

Special emphasis is placed upon an immediate visit to the doctor for a check-up at the slightest suspicion of cancer. A summary of possible signs of the disease is given, based on information from cancer authorities. "Faithfully follow your doctor's advice," urges the message. "If you have a beginning cancer, he can detect it, treat it, save your life."

Members of the medical profession, cancer organizations, and public health agencies who reviewed the message prior to publication commended the optimistic, encouraging tone of the text. A leading cancer authority terms it "constructive, far-seeing, attractive, and effective. The thing that makes a real impression on me is the positive approach to cancer, as well as the use of a cheerful and specific appeal."

COMMUNIQUE

February 17, 1945.

To the Editor:

It's been quite a while since I've written but we just neglect such things. I'm now in ** but this country looks about like all the others I've been in over here.

They say there is quite a bit of malaria up here. I'll probably find out what it is before too long. Our unit has been lucky for we've had only a few cases since we've been overseas. There have been several cases of amebic dysentery. Some of them have not done so well and have been in the hospital several times with it.

We now look forward with some dread to the hot weather that we know is not very far away, then we will be sweating night and day.

I want to express my thanks for the letters received and for The Journal.

Let's hope this war will soon be over and we can all get back to good old Arkansas.

Yours truly,

Ulys Jackson, Capt., M. C.

THE JOURNAL

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W. R. BROOKSHER, M. D., Editor
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EDITORIAL

DON'T NEGLECT CANCER

CLARENCE C. LITTLE, S. D.
Managing Director, American Cancer Society

Never before have we been so aware of the life-saving power of scientific research. Out of the laboratories and on to the firing line where millions of our young men are risking their lives, have gone sulfa drugs, penicillin, dried blood plasma. From the past we can take the names of killers conquered by science—yellow fever, small-pox, diphtheria, typhoid.

Today research against cancer stands on the threshold of new and great advances. It has already given us ways of producing and of controlling the production of the disease in laboratory animals. It has begun to give us knowledge of how cancer cells differ from normal cells.

But cancer research needs financial support and more trained workers. It must be given the material aid and security to make it efficient and increasingly powerful.

Never before have we understood so well how to organize for the detection of precancerous

conditions or to identify cancer in its early and curable stages.

Few as yet realize the nature of the emergency which cancer presents. There are 17,000,000 living Americans who will die of cancer unless something is done. There are at least 5,500,000 of them who can be saved from death from cancer by simple, direct means.

You who read this are one of the "means" by which these lives can be saved. Learn the danger signals that may mean cancer and the ways in which the risk of cancer may be decreased. Pass this information on to others. Enlist during April in the Field Army of the American Cancer Society. If one of the danger signals appears either in your own life or in that of a friend insist on prompt, fearless action. Go to your doctor for examination and advice.

Education alone can save millions of lives even if research does not advance. No one can afford to be too busy to neglect this challenge. It is a choice between intelligent protection of yourself and those you love on the one hand, and ignorant risk of health, happiness and perhaps life itself, on the other.

The American Cancer Society has been for over 30 years the one great national organization devoted to study and development of plans for cancer control. It stands firmly on three fronts where it is face to face with the enemy—Research, Service, Education. It is going forward in support of all of these fields. It is going to take with it millions of Americans, who realize the great need and their power to help.

The American Cancer Society has a division of its Field Army near where you live. It is the Arkansas Field Army, 219 First National Building, Fort Smith, Arkansas.

ARKANSAS STATE CANCER COMMISSION

The 1945 Legislature passed and the Governor has signed Act 277 providing for the creation of the State Cancer Commission. The Commission is to be composed of the Governor, the Chairman of the Committee on Cancer Control of the Arkansas Medical Society and three members to be appointed by the Governor. Two of the appointive members shall be members of the Arkansas Medical Society selected from a list of at least twice that many submitted by the Arkansas Medical Society. The third appointive member shall not be a member of the medical profession. The Commission is empowered to "conduct cancer clinics in such parts of the state as they may deem most advantageous for the

public welfare and shall engage in a program of cancer education in cooperation with established cancer educational organizations, utilizing therefor the facilities of such cancer educational organizations, private physicians and hospitals in the state and the University of Arkansas School of Medicine."

An appropriation bill makes available twenty-five thousand dollars per year for the next two years for the use of the Commission. The Act becomes effective June 10, 1945.

RANDOM THOUGHTS OF THE SECRETARY

February 28th. After all, Cinderella got along well enough with a midnight closing order.

March 10th. Enjoying Tulsa's resplendent amateur ice show tonight and the professional "Follies" need not disturb itself over talent in the post-war era; Tulsa has it.

March 11th. Today visiting the Davis firearm collection in Claremore, said, and we readily believe, to be the largest individually owned collection of firearms in the United States.

March 13th. Chamberlain ably presents the subject of constrictive pericarditis to the county society and from its reception by the audience we shall expect to look closely in the immediate future for the "quiet, small heart" under the fluoroscopic screen, and thus medical knowledge advances under our present system in these United States.

March 15th. With the attendance at today's VD Council luncheon a tribute to the energy and enthusiasm of Goldstein, the navy medical officer conspires to make it "Goldstein Day" since his remarks effectively diminish our heckling arguments.

March 15th. Tonight renewing collegiate friendship Commander Fears with whom we had active extra-curricular interests at Tulane, none of which, however, fitted him for his present activities as a VD control officer. For the first time in our recollection, Tulanians predominate at a quasi-medical gathering in the old home town and we make the most of it.

March 16th. Visiting Camp Gruber, Oklahoma, tonight and finding another effort in the successful prosecution of the war—four military police attired in white gloves and helmets guarding the bungalow of a major general, inquiry developing that this is a routine 24-hour procedure.

March 20th. It will be agreeable to us if the authorities lock up murderer Hall now and quit driving him all over the state.

COMMUNIQUE

March 8, 1945.

To the Editor:

Thought you might like a copy of our new paper **. Our hospital units have been shifted again. In addition to caring for ** casualties, we are running a station hospital for GI's. Manage to keep quite busy. There are many new and interesting developments in this theater. Nothing definite on rotation as yet, but we keep hoping for the good word.

Sincerely,

Robert H. Johnston, Lt. Col., M. C.

PROCEEDINGS OF SOCIETIES

Lincoln County Medical Society has elected the following officers: President, C. W. Dixon, Gould; Vice-president, B. L. Bailey, Star City, and Secretary-treasurer, B. M. Gardner, Star City.

Clay County Medical Society has elected the following officers: President, N. J. Latimer; Vice-president, O. H. Clopton; Secretary-treasurer, J. E. McGuire; Delegate, F. H. Jones, and Alternate, J. P. Hiller.

The Pulaski County Medical Society was addressed March 5th by Fred W. Harris, "Penicillin in Medicine," and Joe. F. Shuffield, "Penicillin in Surgery." L. L. Fatherree, Secretary.

Phillips County Medical Society held its annual meeting February 27th, its 74th anniversary, and elected the following officers: President, E. F. Norton; Vice-president, J. W. Nichols; Secretary-treasurer, M. Fink; Delegate, J. W. Butts, and Alternate, W. A. Ellis.

Union County Medical Society has elected the following officers: President, E. J. Munn; Vice-president, G. D. Murphy, Sr.; Secretary-treasurer, M. V. Russell; Delegates, B. L. Moore and D. E. White, and Alternates, E. J. Munn and S. J. McGraw.

The Benton County Medical Society met in dinner session at Bentonville March 8th for case presentations on rheumatic fever by W. A. Pickens. Geo. M. Love, Secretary.

Dr. and Mrs. P. W. Lutterloh entertained the members of the Craighead-Poinsett County Medical Society at Jonesboro recently honoring the Auxiliary, the retiring president, Ira Ellis, and the secretary, J. H. McCurry. Speakers were: Eric Rogers, Joe Clay Young, J. P. Womack and Dr. L. H. McDaniel, with musical numbers by Bill Thompson and Mrs. Pete Blanton of Marked Tree. J. H. McCurry, Secretary.

Hot Spring County Medical Society has elected the following officers: President, T. L. Hodges; vice-president, H. L. Brown; secretary-treasurer, C. S. Pool; delegate, W. G. Hodges, and alter-

Pope-Yell County Medical Society has elected the following officers: President, W. O. Young; vice-president, Roy I. Millard; secretary-treas-

urer, Ellis Gardner; delegates, A. B. Tate, Sr., and W. E. Ballenger, and alternates, L. Gardner and Lee Montgomery.

Howard-Pike County Medical Society has elected the following officers: President, Edwin V. Dildy, Mineral Springs; Vice-president, J. G. Waldrop, Nashville; Secretary-treasurer, M. D. Duncan, Murfreesboro; Delegate, J. G. Waldrop, and Alternate, E. V. Dildy, Nashville.

The Miller-Bowie Counties Medical Society met in dinner session at Texarkana March 15th for the following program: "Operative Treatment of Hypertension," S. R. Snodgrass, Galveston, Texas, and "Pilonidal Cyst," Wm. Hibbitts, Texarkana. Geo. W. Parson, Secretary.

The Sebastian County Medical Society was addressed March 13th by Chas. T. Chamberlain, "Chronic Constructive Pericarditis: Report of Cases." D. W. Goldstein, Secretary.

Montgomery County Medical Society has elected the following officers: President, J. H. McLean; secretary, G. E. Watkins, and delegate, W. D. Freeman.

Dallas County Medical Society has elected the following officers: President, H. A. Cheatham; vice-president, W. P. Ward (in military service); secretary-treasurer, J. E. M. Taylor; delegate, E. E. Estes, and alternate, J. E. M. Taylor.

RESOLUTION

Whereas, God in His infinite wisdom has removed from our midst our good friend and colleague, Dr. Fergus O. Mahony;

Whereas, we feel the personal loss of a good loyal friend upon whom we had the greatest confidence, respect and dependence;

Whereas, we feel that the profession, as well as our state, our nation and the common people of this community, has lost a true and tried physician and friend;

It is now resolved, that the Union County Medical Society deeply feels and realizes its loss. We sincerely express to his family our heartfelt sympathy in the loss they have suffered; that a copy of this resolution be spread upon the minutes of this meeting, that a copy be sent to the family and a copy to The Journal of the Arkansas Medical Society.

J. B. Wharton, Sr.,
M. V. Russell,
A. D. Cathey.

PERSONALS AND NEWS ITEMS

Lt. Comdr. Raymond C. Cook, Little Rock, is now on sea duty.

Comdr. A. G. Sullivan, Hot Springs National Park, is now on sea duty.

W. M. Owen has moved from Armored to Parkin.

Lt. Comdr. Charles S. Paddock, Fayetteville, is now stationed at Camp LeJeune, North Carolina.

Pearl Waddell, Fort Smith, recently addressed the Delta Kappa Gamma sorority of that city on "Socialized Medicine."

D. W. Goldstein, Fort Smith, attended a venereal disease conference in Oklahoma City, March 2nd-4th.

S. J. McGraw has been appointed city health officer at El Dorado.

Lt. Jack W. Kennedy, Prescott, is now stationed overseas with an evacuation hospital.

Geo. V. Lewis, Little Rock, has returned to practice after an absence of several months.

F. Walter Carruthers, Little Rock, addressed the Chicago Orthopedic Society March 9th on "Anatomical and Functional Reductions of Fractures of the Pelvis." Dr. Carruthers visited Los Angeles, San Francisco and Phoenix, later in March.

Maj. James M. Walls, Blytheville, is now stationed at the Prisoner-of-War camp, Huntsville, Texas.

Capt. James O. Pierce, Marked Tree, is now stationed at an army air force base in Santa Monica, California.

Capt. Ellis P. Cope, Little Rock, is now stationed with the 4100 Base Unit, Patterson Field, Ohio.

Capt. James W. Burnett, Texarkana, is now stationed overseas with an infantry regiment.

Capt. Frank C. Maguire, Augusta, is now stationed overseas with a general hospital.

Capt. James L. Pickens, Bentonville, is now stationed overseas with a general hospital.

Paul C. Eschweiler, Little Rock, addressed the El Dorado Kiwanis Club March 7th on the program of the blood bank of the University of Arkansas School of Medicine.

J. J. Hudgins has been elected a school director at Paragould.

Lt. Jack A. King, Elaine, is now stationed overseas with a general hospital.

Capt. Charles P. Wickard, Little Rock, is now stationed at Regional Hospital, Camp Robinson, Arkansas.

Lt. John P. Eaton, Little Rock, is now stationed overseas.

Capt. Charles W. Rasco, Jr., DeWitt, is now stationed at the Army Air Field, Great Bend, Kansas.

Capt. W. R. Parsons, Little Rock, is now assigned to the 313th General Hospital, Camp Cooke, California.

Comdr. James W. Amis, Fort Smith, has been assigned as medical inspector for the Eighth Naval District.

L. J. Kosminsky, Texarkana, has returned to practice after a prolonged illness.

Major Lewis M. Henry, Fort Smith, is now stationed at Tinker Field, Oklahoma City, Oklahoma.

Capt. Charles C. Reed, Jr., Little Rock, is now stationed at Fort Sill, Oklahoma.

Maj. U. R. Elferts, Hot Springs National Park, is now assigned to Station Hospital, Camp Hood, Texas.

Lt. Gilbert O. Dean, DeQueen, is now stationed at the Marine Corps Air Station, El Centro, California.

Raymond E. Smallwood, Hot Springs National Park, now stationed in the Office of the Surgeon General, Washington, has been promoted to major.

E. J. Easley, Little Rock, recently addressed the Lake Village Chamber of Commerce.

Woodrow E. Phipps, North Little Rock, now stationed overseas, has been promoted to captain.

OBITUARY

CLIB B. MAY, age 64, died suddenly February 23rd in his office in Little Rock. Born in Okolona, he graduated from the University of Louisville School of Medicine in 1914 and practiced at Gurdon before moving to Little Rock in 1920. He was a member of the Pulaski Heights Methodist Church and of the Scottish Rite bodies. Surviving relatives are his wife and three daughters.

MEMORIAL TO DR. MADELINE M. MELSON

On the morning of January 12, 1945, this community was shocked by the news of the sudden death of Dr. Madeline Melson. She had lived here since 1923, and had made a commendable record in the medical profession.

Dr. Melson prepared herself thoroughly for her profession, graduating from University of California, internship at San Francisco Hospital, and afterwards a fellowship post-graduate course at the Mayo Clinic. She always manifested a keen interest in keeping abreast with the modern developments in scientific medicine. She advanced her specialty by organizing the Arkansas Society of Pediatrics, which held several successful meetings. Probably her most outstanding trait was the enthusiastic zeal with which she cared for her patients. She gave more than required professional care and treatment.

While carrying on her fine work in the medical field, she did not neglect her duty as a home-

maker. She gave her best to her family. Her home was always a model of art and neatness. She was a loyal wife, and a good mother.

Another outstanding trait of Dr. Melson was the confidence which she inspired in her friends. She had a wide circle of friends, and every one of them knew that her friendship was genuine.

We cannot understand God's plan, as He removes a great life from us at such an early age. We know, however, that Dr. Melson has left a host of loyal friends and a valuable contribution to her profession.

May the spirit of Dr. Madeline Melson's work ever live in the hearts of her fellow physicians.

— Dr. Robert Watson,
Dr. Paul Mahoney,
Dr. M. J. Kilbury.

WOMEN'S AUXILIARY NEWS

The Auxiliary to the Sebastian County Medical Society met March 12th for luncheon, business meeting and program. Mrs. M. E. Foster, Fort Smith, and Mrs. C. W. Hall, Greenwood, were hostesses.

The president, Mrs. B. L. Ware, conducted the business session, she appointed Mrs. W. F. Rose, Mrs. Walter G. Eberle and Mrs. Charles T. Chamberlain a nominating committee to prepare a slate for election of officers, to be presented at the April meeting of the Auxiliary.

The Auxiliary voted to renew annual contributions to "Hygeia," official publication of the medical association; contributions to the Girls' Club, Young Women's Christian Association; Rosalie Tilles Children's Home, Booneville Tuberculosis and Wildcat Sanatorium.

At the conclusion of the business session, Mrs. W. R. Brooksher, Jr., commander of the Arkansas Field Army of the American Cancer Society, presented plans for the 1945 program. The Field Army will conduct a state-wide campaign during April on education and early recognition of cancer.

"Without the discovery of a single new cancer fact, 30 to 50 per cent of potential cancer victims can be saved through an adequate educational program, adequate detection clinics and periodical medical examinations," Mrs. Brooksher said, quoting from a bulletin of the American Cancer Society.

A drive for \$5,000,000 during April designated

as "Cancer Control Month," will carry out a national program for public education, research, and the establishment of cancer detection clinics.

Mrs. Miles Everett Foster, Jr., and Mrs. E. Z. Hornberger were guests of the auxiliary. Members attending were Mrs. B. L. Ware, Mrs. W. R. Brooksher, Jr., Mrs. D. W. Goldstein, Mrs. Everett Moulton, Mrs. M. E. Foster, Mrs. S. P. Stubbs, Mrs. W. F. Rose and Mrs. C. W. Hall, Greenwood.

Mrs. W. F. Rose,
Publicity Chrmn., Sebastian County
Medical Society Auxiliary.

Bowie and Miller County Medical Auxiliary met in the home of Mrs. Allen Collom February 22nd. Co-hostesses with Mr. Collom were Mrs. A. W. Roberts and Mrs. T. F. Kittrell. The meeting was opened by repeating Psalm 19:14 in unison.

Resolutions in memory of a valued member, Mrs. L. H. Lanier, were read.

The business session was conducted by Mrs. R. R. Kirkpatrick, first vice president. The slate of new officers was read by Mrs. Harry Murry, as follows: Mrs. William Hibbitts, president; Mrs. N. B. Daniel, president-elect; Mrs. Roy Baskett, first vice-president; Mrs. J. H. Rives, second vice-president; Mrs. Allen Collom, third vice-president; Mrs. L. J. Kosminsky, fourth vice-president; Mrs. Ralph Cross, recording secretary; Mrs. A. G. Lee, corresponding secretary; Mrs. Chester Kitchens, treasurer; Mrs. Joe Tyson, historian; Mrs. Reavis Pickett, publicity; Mrs. R. R. Kirkpatrick, parliamentarian.

Mrs. J. H. Rives, speaker, gave an interesting and clever talk on "How to Acquire Good Looks." She stressed health, personality, character, carriage, and correct dress as important factors in looking one's best, giving pointers on the various factors which go to make a pleasing appearance.

Visitors welcomed included Mrs. C. L. Macey of Morrilton, Ark., niece of Mrs. Brooks Tate, Mrs. John B. Williams of Shreveport, and Mrs. W. K. Read.

Mrs. Roy Baskett played a lovely piano number, "Nocturne in D-flat" (Chopin).

The home was decorated throughout with a wealth of spring flowers, including bowls of cut flowers and potted plants. In the dining room, refreshments were served by Mrs. R. R. Kirkpatrick and Mrs. William Hibbitts from a beautifully decorated table.



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A PLEA FOR CONSERVATISM IN THE MANAGEMENT OF ACUTE CARDIAC CRISES*

A. T. BARR, M. D., Cherry Valley

Perhaps the most simple method of approach to a discussion of the treatment and management of acute cardiac crises would be to review briefly the etiology and resultant pathology of all these occurrences. We find, in so doing, that they all fall into three classifications etiologically, and two, pathologically.

Etiology is divided into:

1. Infections. Here we have to consider only rheumatic fever, scarlet fever, and syphilis. Circulatory crises may be encountered in other infections, but these are the only ones with especial predilection for the myocardium.

2. Nutritional deficiencies. Here we have to consider the Vitamin B deficiencies and thyrotoxicosis. In this locality we perhaps need consider only the Vitamin B deficiency associated with alcoholism, and thyrotoxicosis.

Pathologically, both of these etiological classifications result in an acute myocardial degeneration characterized by a marked acute glyco-gen deficiency and greatly increased irritability of the heart muscle.

3. Circulatory or vascular lesions.

These account for by far the greater number of the acute cardiac crises. An efficient supply of blood must be furnished the myocardium, commensurate quantitatively and qualitatively with the amount of work to be done by the heart. In arteriosclerosis the added peripheral resistance has resulted in hypertrophy of the myocardium to meet the demand for extra work. With this hypertrophy is associated both a relative and an absolute reduction in blood supply to the heart muscle, due to the hypertrophy of the walls of the coronary arteries, the consequent reduction in the size of their lumina, and the obliteration of arterioles. These changes pro-

duce a relative ischemia of the myocardium. These facts explain why myocardial failure is the most frequent terminal event in hypertension. In paroxysmal hypertension there is usually associated a paroxysmal coronary constriction or occlusion leading to increased fibrosis and ischemia. Valvulitis may lead to either insufficiency or stenosis, or both. **But**, such anatomical lesions led to acute failure only by adding to the burden of an already damaged myocardium. They produce no functional impairment during compensation.

Hence, as already pointed out, the underlying pathological condition in this classification is one of hypertrophy with fibrosis and ischemia.

Acute congestive heart failure may come on suddenly in any of these conditions with dilatation of one or both ventricles following exertion; or may be ushered in with auricular tachycardia or flutter, or auricular fibrillation. Or, **any** of the arrhythmias may occur.

Treatment

The first indication or treatment is, of course, if the opportunity has presented itself, to prevent the crisis if possible, by removing the cause, if it can be removed, or by so treating or managing the cardiac patient that his crisis will not occur.

But before entering upon the discussion of the active treatment of the various crises, let us first consider the various agents at our disposal, and their modes and manners of action. These agents are both physical and chemical.

The physical agents we may ordinarily employ are: cold applied to the precordium; heat applied to the precordium, or to the whole body; a tight abdominal binder; position; and artificial respiration (oxygen).

Cold decreases the irritability and conductivity of the myocardium. Hence, in rapid, irritable hearts, an icebag applied to the precordium will frequently give marked subjective and objective relief. Conversely, heat increases the irritability and conductivity of the heart muscle. Consequently, heat to the precordium is indicated whenever it is desirable to increase the irritability or conductivity of the heart. To the

*Read before the Third Councilor District Medical Society, Brinkley, October 27, 1944.

entire body heat is a **MUST** whenever there are exhibited the symptoms of shock, as in coronary embolism. The tight abdominal binder is always indicated in congestive heart failure from whatever cause. The semi-recumbent, or even sitting, position is beneficial in all congestive failures; and the supine in all others. Artificial respiration may become a necessity in any crisis, and may be the final means of saving a life. It should not be discontinued so long as there is any possibility of prolonging or saving life by its use.

The drugs, or chemical agents at our disposal are: digitalis; quinidine; morphine; vitamin B; the xanthine group, principal of which are caffeine and theobromine; adrenalin; coramine; and the mercurial diuretics. Each of these deserves careful consideration before its exhibition in any cardiac crisis.

Of these, digitalis deserves first consideration. Where indicated, no drug can give such brilliant results. But it is perhaps more abused than any other one drug, and its misuse can be fraught with grave danger. This agent acts upon the heart in several ways: (1) by slowing it through action on the vagus; (2) it shortens the refractory period of the auricle, but prolongs it in the auriculo-ventricular node and bundle, thus reducing the **conductivity** of the heart; (3) in therapeutic doses it increases systolic contraction. (No dose sufficiently large to decrease diastole should ever be given); (4) it increases the irritability of the myocardium; (5) it increases the flow of blood through the coronaries; (6) it inverts the T-wave of the electrocardiograph; and (7) it produces symptoms of intoxication. When administered, watch carefully for these, and discontinue or reduce the dose promptly upon their appearance.

The indications for its use are: (1) congestive heart failure, with or without auricular flutter, fibrillation, or partial heart block, when this acute congestive failure is due to circulatory or vascular lesions; (2) tachycardia due to dilatation.

The contra-indications to its use are: (1) a high degree of heart block, whether or not associated with Stokes-Adams syndrome; (2) infectious or nutritional heart failure; (3) far advanced myocardial degeneration, even though due to vascular lesions, and (4) idiosyncrasy (inquire).

Adrenalin and coramine act principally by their action upon the respiratory and vasomotor centers; with stimulation of the sympathetics, constricting the splanchnic area. There is a secondary action upon the vessel walls and the myocardium.

The xanthine group. Caffeine acts upon the central nervous system as a direct stimulant. To a lesser extent, theophylline stimulates the respiratory and vasomotor centers. Stimulation of the inhibitory center may slow the pulse slightly. Caffeine also directly stimulates the pace-maker and the heart muscle. It dilates the coronaries, increasing their blood carrying capacity. Caffeine, together with the other xanthines greatly increases the secretion of urine by direct action upon the kidneys, thus greatly aiding in the elimination of wastes and toxins from the system. Perhaps the best agent for this purpose, with less action upon the central nervous system, is theobromine with sodium salicylate. It is very efficacious in the removal of edema in cardiac conditions.

Vitamin B simply supplies the need promptly in the deficiency crisis.

Morphine, as we all know, acts by relieving pain, quieting the nervous reaction, and slowing and steadying the heart.

Quinidine. Quinidine is unquestionably the drug of choice in the infectious and nutritional crises and most of the arrhythmias. Its action is direct upon the sino-auricular node, or pace-maker, slowing the action of the heart and increasing the strength of systole. Also it increases the conductivity of the auriculo-ventricular node and bundle as well as that of the heart muscle, which action **may** accelerate the ventricular systolic rate.

Mercurial diuretics and acidosis producing drugs, in my opinion, have no place in the management of acute crises. But they may be useful adjuncts in after-treatment, or in warding off an attack, providing there is **ABSOLUTELY NO** active nephritis.

Indications and contra-indications. These drugs are indicated where digitalis is contra-indicated, and contra-indicated where digitalis is indicated.

Dosage and administration. Dosage should be conservative. It is better to give small doses repeated more often than to give large doses until effects are observed. Too much cannot be said against an initial large dose of digitalis, for once it is given the effects cannot be satisfactorily controverted. All drugs given in acute crises (with the exception of theobromine with sodium salicylate) should be administered intravenously and effects carefully observed. Later other routes of administration may well be chosen. But, above all, **DO NOT OVER-TREAT**, and thereby whip out a flagging heart.

The Common Crises and Their Management

The most frequently encountered crises are: Acute congestive failure, the arrhythmias, and thyrotoxicosis.

1. Acute congestive heart failure is by far the most frequently encountered cardiac crisis. The indications for its management are: (1) to aid respiration; (2) to overcome the congestion of blood in the abdomen; and (3) to support the heart. Respiration may best and most quickly be aided by position. This may vary from propping the patient in a semi-erect position to placing him upright in a chair, with the arms supported and the feet partially elevated. A wide, tight abdominal binder will be found quite efficacious in combating the passive congestion. The support of the heart depends upon the etiology of the attack.

If due to avitaminosis, the indications are to stimulate gently with caffeine intravenously if indicated; vitamin B intravenously; easily digested vitamin rich foods and glucose; and one of the xanthine group by mouth as soon as it can be safely administered.

If due to infection, the treatment is the same, except that there is not the urgent need of the vitamin.

However, if the congestive crisis is due to circulatory lesions, digitalis is the one drug indicated. The average initial dose is 1 c.c. intravenously. Observe its effects carefully and do not subsequently overdose thereby applying the whip that will wear out the myocardium. Be satisfied with slow but continuous improvement. Give the myocardium a chance to recuperate, always remembering that it is practically exhausted, and **must** be re-nourished.

In a far advanced fibrous degeneration digitalis will produce fibrillation and death. All you can do is nurse, nourish, and rest the patient. Any stimulant should be very cautiously employed.

In all of these congestive failures morphine will most probably be indicated to allay the mental anguish and distress and procure rest. Do not hesitate to use it. And, keep the patient warm. (They want to throw cover.)

2. The arrhythmias.

An occasional auricular or ventricular extrasystole may usually be well disregarded. It is a better policy to disregard it than to warn and so excite the patient about an occurrence that will probably never amount to anything. But auricular flutter or fibrillation, or paroxysmal tachycardia, either auricular or ventricular, may well terminate the patient's life through exhaus-

tion of the myocardium if not controlled.

A. Paroxysmal auricular tachycardia.

Pressure on the right carotid tubercle, pressure on the root of the neck on the right side, pressure upon the eyeballs, or having the patient bend over, at the same time holding the breath in extreme exhalation may terminate an attack. An ice-pack upon the precordium is frequently very effective. When these more simple means fail I have found quinidine usually very effective. The average dose I have employed is three grains every four hours, given intravenously at first.

B. Auricular flutter.

The first indication is an ice-bag over the precordium. The second is quinidine. Quinidine acts by slowing the auricular rate through direct action upon the sino-auricular node. But it reduces the refractory period of the auriculo-ventricular node and bundle, so increasing the ventricular rate. This may permit a synchronization of the auricular and ventricular rates, after which the heart will slow down as a whole. Should the ventricular rate be accelerated alarmingly it may be controlled by adding digitalis to the treatment. Digitalis alone, we are told, may convert flutter into fibrillation, following which a normal rhythm may be restored. But, the fibrillation may produce sudden death. (I have never had the nerve to try this method of treatment.)

C. Auricular fibrillation.

Try to control by an ice-bag over the precordium with quinidine intravenously. The pulse is very small and irregular and the condition is alarming. Relax the patient with morphine; keep him in a horizontal position, or with the head low. Apply heat to the body to maintain warmth.

D. Heart block.

In the first stage, that of an occasional missed beat; or the second stage, that of 2:1, 3:1, or 4:1 rhythm, all that can be done is to safeguard the patient against exertion, fright, anger or excitement. The pulse is slow, full and forceful. Systolic pressure is increased and diastolic pressure is decreased. It resembles the pulse of aortic regurgitation but falls less fast. In the third stage, that of complete dissociation, there is STILL nothing to do more than to keep the patient quiet and comfortable. The treatment is **ultra conservatism**.

E. Paroxysmal ventricular tachycardia.

There is little to do. Apply an ice-bag over the precordium and give morphine (or hypnotics) for rest. Eliminate tea, coffee, tobacco and alcohol.

F. Coronary spasm and occlusion.

The first indication is for conservatism in differentiation. If occlusion is erroneously diagnosed as spasm and nitrites administered death may result. But if morphia is given, and the condition proves to be only spasm, or angina pectoris, no harm has been done. However, if the condition proves to be embolism, a great deal of good has been done. The one most effective remedy has been administered early. Continue it to the accomplishment of complete relaxation. Apply an ice-bag to the precordium, and heat to the body. Artificial respiration may save a life that would otherwise be lost. Continue complete bed rest.

3. Thyrotoxicosis.

This is the one crisis in which the treatment is anything but conservative. Moments count. The indications are: large doses of caffeine sodio-benzoate intravenously, combined with coramine and adrenalin, repeated until response; glucose intravenously, and artificial respiration long continued. Apply a hot water bottle to the precordium, and heat to the entire body.

Summary

1. Practically all cardiac crises are better treated cautiously than energetically.

2. Digitalis is indicated only in crises due to circulatory lesions, not too far advanced. I believe that many lives have been sacrificed by indiscriminate use of the drug.

3. Always give the myocardium an opportunity to exhibit its remarkable recuperative ability, instead of irritating it into tremor, and thereby precipitating death.

COMMUNIQUE

March 31, 1945.

To the Editor:

I have been reading "Random Thots" for the past six months. It has followed me monthly from Camp Robinson to ** and now **. I've been in **, too, but only for a short time.

Mine is the typical story of the battalion surgeon. I'm the only M. C. in these parts, and if it were not for the occasional Journals, I would be lost among the combat engineers.

I am yet to meet any Arkansas doctors on this side, but everywhere I go I meet men who know someone from home and were stationed with them. It feels good just to talk about mutual acquaintances.

My regards to everyone. Say "hello" for me in the next edition of "Random Thots."

Sincerely,

Alvin Strauss, Jr., Lt., M. C.

MODERN CONCEPTS OF CARDIO-VASCULAR DISEASE

COMMITTEE ON THE HEART
ARKANSAS MEDICAL SOCIETY

C. T. Chamberlain, M. D., Chairman, Fort Smith

HYPERTENSION AS VIEWED FROM ITS SURGICAL TREATMENT Part II

The concept of a primary renal mechanism in human hypertensive disease has been also questioned by Homer Smith and his associates, particularly Goldring and Chasis. The evidence upon which their viewpoint is founded is of an entirely different nature. Their opinions are based upon a study of the physiology of the kidneys of living hypertensive patients. Their detailed quantitative studies of renal blood flow in normal and hypertensive patients by means of inulin and diodrast clearances represent a great advance in human physiology. They conclude that "renal ischemia is not the primary etiological event in human hypertensive disease; rather, the renal ischemia observed in hypertensive patients appears to be one of the sequelae of the hypertensive process." They feel, however, that their data favors a humoral concept and note that "since the relative ischemia in these hypertensive patients is associated with a rise in the filtration fraction, it is concluded that the ischemia is the result of increased resistance beyond the glomeruli, that is, in the efferent glomerular arteriole. This suggests that in hypertensive disease there may be present in the blood one or more pressor agents which produce constriction of the efferent glomerular arterioles; this renal hemodynamic alteration is associated with impairment of tubular functional activity. It is not known which of these changes precedes the other."

The concept that hypertension is the result of primary disease of the renal arterioles has been further questioned by evidence resulting from the surgical treatment of hypertension by excision of considerable portions of the sympathetic nervous system, particularly that having to do with the vasomotor innervation of the visceral vascular (splanchnic) bed. These data have to do with the pathological changes in the kidneys of living hypertensive patients, who, however, were suffering from well established hypertension, with persistent elevation of the diastolic pressure to 100-162 m.m., which in 60 per cent of the cases exceeded 120 m.m. of mercury in the rest-

ing horizontal position, many being clinically in a late stage of the disease. This evidence is of two sorts, which may be briefly summarized as follows: (1) Over 1,000 kidneys of over 500 living hypertensive patients have been viewed in gross. It can be stated that contracted granular kidneys, or cachectic kidneys, or, except in rare instances, irregularly scarred and contracted kidneys, are unusual in living hypertensive patients. Little evidence of gross pathology is the rule. (2) Renal Biopsies. These have been studied in detail and the findings in the first 100 consecutive cases were recently described by Castleman who states, "the most striking result of this work is the finding of such a high percentage of renal biopsies in which there is no or only minimal vascular disease." Among the conclusions it was noted, "in contrast to the almost invariable finding of well developed arteriolar disease in the kidneys of hypertensive patients observed post-mortem, 28 per cent of the biopsies showed no or only insignificant vascular disease and an additional 25 per cent merely mild changes. From the observations it is concluded that the morphological evidence of renal vascular disease in more than half of the cases was inadequate to be the sole factor in producing the hypertension and that in many of these and probably others the hypertensive state antedated the renal vascular lesion, which, once established, probably aggravated the hypertension. These observations are not in keeping with the concept that renal ischemia due to pre-existing renal vascular disease is the cause of essential hypertension in man."

The concept that renal ischemia, either actual or relative, must invariably antedate human hypertension has been questioned by the renal clearance studies of Talbott et al., carried out in twenty of these cases having renal biopsies. As in the larger series of 100, the degree of vascular change was graded from 0 to 4. They concluded, "renal clearance studies performed on 20 cases of essential hypertension showed a significant correlation with the microscopic appearance of their respective renal tissues, i. e., the more severe the renal vascular disease the more reduced were the glomerular filtration rate and the renal blood flow. In the cases with grade 0 and 1 renal vascular disease, the renal clearance observations were either normal or only slightly reduced. Only in grade 4 renal vascular disease was renal blood flow seriously reduced. The filtration fraction was normal in 7 of 8 cases in biopsy groups 0, 1 and 2. It was increased in 6 of 11 cases in biopsy groups 3

and 4. These findings indicate that constriction of the efferent glomerular arterioles was not present in the early stages of renal vascular disease."

That portion of the renal humoral concept which would explain hypertension as resulting from the vasoconstrictor action of a substance acting directly and independently upon smooth muscle, due solely to renal ischemia resulting from pre-existing renal arteriolar disease, has been questioned by the persistent and significant lowering of blood pressure which has followed the surgical treatment of many hypertensive patients. The effect of surgery in man should be contrasted with the lack of effect of similar operations upon the blood pressure of dogs rendered hypertensive by the Goldblatt technique. In many instances, human hypertension bears a closer resemblance to neurogenic forms of experimental hypertension in so far as the latter can also be modified or abolished by excision of appropriate portions of the autonomic nervous system.

Summary

It would appear that data pertaining to the gross appearance of the kidneys, accumulated during the course of the surgical treatment of hypertensive patients, indicate clearly that contracted granular kidneys do not antedate the hypertensive state in man.

For the first time, an opportunity for the microscopic study of renal arterioles of living patients with continued hypertension has presented itself. The findings are also at variance with autopsy material. They suggest that pre-existing renal arteriolar disease of a moderate or marked degree is not a sine qua non to the hypertensive state.

For the first time, an opportunity has arisen whereby the pathological changes can be correlated with the physiological state of the kidney. It has been noted that neither a marked reduction in quantity (ischemia) nor a change in the nature of renal blood flow (constriction of the efferent glomerular arteriole) is obligatory to the hypertensive state.

When renal vascular disease and hypertension are associated, it is difficult to disprove a cause and effect relation; and no one questions the importance of renal disease, when present, as a factor in human hypertension. However, to make this a universal explanation for hypertension in man is not in keeping with the facts. A concept is needed, which will explain the cause of hypertension in the absence of kidney

disease, and the absence of hypertension in the presence of kidney disease.

It may be that nervous and humoral mechanisms can join with vascular disease, in one area or another, in an infinite variety of combinations to result in hypertension, a collaborative enterprise as it were. And also, other factors as yet unmentioned or emphasized, may be introduced into the picture as time goes on. It is quite possible that the participation of all factors is not obligatory in every case.

The surgical treatment of hypertension has introduced a new factor, the autonomic nervous system, into the already complicated picture of the hypertensive state in man. It has contributed data which cast doubt upon the primacy of renal arteriolar disease as the sole causative factor. By virtue of persistent and significant lowering of blood pressure attended by other favorable changes, lumbodorsal splanchnicectomy appears to be a useful adjunct to the medical management of many cases of so-called essential and malignant hypertension in man.

Acknowledgment is hereby made of permission by the American Heart Association to publish the above.

COMMUNIQUE

March 8, 1945.

To the Editor:

I was very happy to receive your "Random Thots" and my 1945 membership card. The February Journal was received a few days ago.

Even though I have been here a very short time I can see the great morale value of your monthly bulletins. I hope that I get every one that is sent out.

I am unable to divulge my whereabouts but have been able to go to ** twice and to see a great deal of the ** countryside. Of course, by the time you receive this letter, I will be nearer Germany than I am right now.

I haven't had the pleasure of seeing any Arkansas medics yet, but I am on the trail of two or three friends. I am very anxious to get The Journal and would it be too much trouble to send me the January and February issues?

I hope to later give you a more detailed account of the happenings here. Just now that is impossible.

Any correspondence will be greatly appreciated.

Sincerely yours,

Jack W. Kennedy, Lt., M. C.

COMMUNIQUE

March 18, 1945.

To the Editor:

The Journal and other correspondence of the Society have heretofore reached me with marked rapidity, but I expect much delayed mail now.

Not so long ago I spent a short leave in Little Rock, and seeing all the boys again was a real treat. Even though they are all very busy, it seems that most of them are gaining in weight with the exception of Alan Cazort. I suppose work just doesn't agree with him.

My new duty is fine, a complete change, but rather interesting work, little as it is. The planners to be say more doctors are needed but that is one I haven't been able to figure out. I guess I am not supposed to but it seems to me that the civilian population's health and treatment should receive more consideration.

Please note the change of address and any mail from that end of the line will be read with enthusiasm.

Sincerely,

Raymond C. Cook,
Lt. Comdr., M. C., USNR.

A TRIBUTE

(Honoring all doctors on Doctor's Day)

Civilian doctors—their historic role
Unsung—as overworking takes its toll.

To Navy doctors, Army medicos,
For doing work which every family knows!
But what about the doctor over there?

His endless, selfless work . . . or his despair?
With frantic haste, in blood and sweat he slaves.
While Japs and Nazis maim and kill, he saves
The shattered ones . . . and makes them whole
again

To live and work once more as useful men!
In mobile hospitals on all the fields
With doctors, litter-bearers at their heels,
With sulfas . . . plasma . . . blood, the surgeon's
knife

Will race with time and death to save a life!
No labor unions clock his time! He slaves
All hours! And all but two per cent he saves!
To doctors over there . . . and over here,
We bring a tribute . . . honest and sincere.

Vera Blood Fletcher, Hot Springs, Arkansas (Poet Laureate for the Women's Auxiliary to the Arkansas Medical Society).

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

ONCE established in the human body, the tubercle bacillus is capable of attacking at many places. Infection of the kidneys, while not uncommon, is often overlooked in its early stages. Partly, this must be blamed on the paucity of symptoms, partly on the fact that renal involvement is usually associated with more obvious disease in other organs, particularly the lungs.

It is well to be reminded of the symptoms, signs and laboratory findings which should lead one to suspect renal tuberculosis. Once the question is raised, there must be an exhaustive search of the patient for evidence that will confirm or allay the suspicion.

EXTRARENAL LESIONS ASSOCIATED WITH RENAL TUBERCULOSIS

Renal tuberculosis is too often symptomatically silent during the time when it can be treated most successfully. The diagnosis of this condition can be made most satisfactorily by the identification of the organism in the urine and confirmed by inoculation of laboratory animals, but in many cases the disease escapes early recognition because tuberculous infection is not suspected. Hence any symptom, sign or laboratory finding that may lead one to suspect the diagnosis of renal tuberculosis is worthy of investigation.

Calcified Mesenteric Lymph Nodes

Calcified mesenteric lymph nodes are seen frequently in the routine roentgenograms of the urinary tract. They attract attention only in the rare cases when it is necessary for them to be distinguished from urinary calculi. Although several conditions are believed to be responsible for the pathologic change in the lymph nodes that is followed by calcification, the vast majority of calcified mesenteric lymph nodes have been the seat of tuberculous infection. This fact prompted the study of the incidence of calcified mesenteric lymph nodes in cases of proved renal tuberculosis. To accomplish this, the intravenous urograms and retrograde pyelograms in 145 consecutive cases of renal tuberculosis were examined. In each of these, nephrectomy had been performed so a pathological as well as bacteriologic diagnosis had been made. This series was compared with a series of 145 consecutive cases of surgically treated renal lithiasis in which the

diagnosis of renal tuberculosis was excluded.

Calcified mesenteric lymph nodes were found to be present in 13 per cent of the roentgenograms of patients suffering from proved renal tuberculosis. This incidence was more than twice that found in a comparable series of patients not suffering from renal tuberculosis.

Tuberculous Epididymitis

Although it is generally known that renal tuberculosis is fairly frequently accompanied by genital tuberculosis, too often intractable epididymitis is treated for long periods before the kidneys are investigated.

In 34 (42 per cent) of the 81 male cases of proved renal tuberculosis incorporated in the preceding study, genital tuberculosis also was present. None of the 93 male subjects in the group with nontuberculous kidneys suffered from inflammation of the genitalia. Thirty-one of the 34 patients had proved tuberculous epididymitis, and the remaining three were believed to have tuberculous prostatitis. In 15 of these cases it was necessary to remove the kidney on the same side as the involved epididymis, and in seven cases the kidney on the opposite side from the involved epididymis was removed. In nine cases both epididymides were involved.

The frequency of concomitant genital and renal tuberculosis is so great that the genitalia of every male patient complaining of urinary symptoms should be carefully examined for evidence of tuberculosis. Although renal tuberculosis frequently occurs in the absence of genital

tuberculosis, the latter is accompanied more often than not by renal tuberculosis. Every male patient who has epididymitis of possible tuberculous nature should therefore receive complete urologic investigation, even in the absence of urinary symptoms. Only in this manner will the early renal lesions of tuberculosis be detected.

Pulmonary Tuberculosis

Since it seems to be the general opinion that renal tuberculosis largely, if not entirely, represents a secondary hematogenous focus of tuberculous activity resulting from a primary pulmonary infection, it was decided to investigate the incidence of pulmonary involvement in these 290 cases. To do this the pulmonary roentgenograms of the 145 proved renal tuberculosis patients and the 145 control patients suffering from operative renal lithiasis were reviewed. As shown

Thoracic involvement	Patients with renal tuberculosis		Patients with non-tuberculous kidneys	
	No. of Cases	Per cent distribution	No. of Cases	Per cent distribution
	145	100	145	100
All types				
Healed or active adult type	50	34	6	4
Healed childhood type (Ghon complex)	20	14	20	14
None	75	52	119	82

in the table, each case was relegated to one of three categories: first, the healed or active adult type of tuberculosis; second, the healed childhood type of tuberculous infection, which often is referred to as the Ghon complex; and finally those not showing any pulmonary pathologic change whatsoever, which were designated as negative.

The findings clearly indicate the frequency in our series with which renal tuberculosis is associated with demonstrable healed or active adult type pulmonary tuberculosis. The frequency of the healed childhood type of tuberculosis was the same in the two series.

Summary and Conclusions

The diagnosis of renal tuberculosis can be established with relative ease once this disease is suspected. Too frequently this condition, whose successful treatment depends on its early diagnosis, is not considered. The incidences of three easily demonstrable tuberculous lesions often associated with renal tuberculosis have been determined. The presence of any of these associated conditions should cause one to suspect renal tuberculosis.

The presence of calcified mesenteric lymph

nodes in the roentgenograms of a patient suffering from a urologic disease should cause one to consider the diagnosis of renal tuberculosis since they are more than twice as frequent in cases of renal tuberculosis as in nontuberculous patients.

Since epididymitis occurred in 38 per cent of 81 cases of renal tuberculosis but did not occur in a control group of 93 cases, every case of intractable epididymitis should be considered tuberculous until proved otherwise. The condition of the kidneys of such a patient should be promptly evaluated.

Since roentgenographic evidence of healed or active adult type of pulmonary tuberculosis is more than eight times as frequent in cases of renal tuberculosis as in a comparable control group, in every case of renal tuberculosis the patient should have the benefit of a stereo-roentgenogram of the thorax. Renal tuberculosis should be excluded in any case of pulmonary tuberculosis with subjective or objective urinary findings.

(Extrarenal Tuberculous Lesions Associated With Renal Tuberculosis, David S. Cristol, M. D., and Laurence F. Greene, M. D., The New England Journal of Medicine, September 21, 1944.)

COMMUNIQUE

March 31, 1945.

To the Editor:

Am always glad to get The Journal and the "Random Thots" which have been keeping up with me pretty well. If you keep up with ** Infantry you can see me get around.

In the last hot action we had men of my collecting company received three Silver Stars and two Bronze Stars. They gave me the Bronze Star for the work my men did.

It looks like this "last heave" is going to do the trick—I hope.

Thanks again for keeping the news coming.

Best regards,

Lewis Hyatt, Capt., M. C.

FOR SALE

Examining and treatment table and several cabinets (Aloe Steeline white).
Lt. Comdr. Geo. F. Stocker, M. C., U. S. N.
National Naval Medical Center,
Bethesda, Maryland.

THE JOURNAL

OF THE

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W. R. BROOKSHER, M. D., Editor

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EDITORIAL

SO YOU ARE TIRED, EH?

The vast majority of you who read these lines are physicians. Of course, our mailing list includes the names of our advertisers; the business managers of various other county organs, with whom we maintain an "exchange"; a few laymen on the "courtesy list" for one reason or another and our wives and office girls. But the "Bulletin" is written primarily by and for the members of the medical profession.

Fairly it may be assumed no one forced you to study medicine. Maybe Mother or Dad wanted you to enter the ministry or to take up law as a profession, but somehow you talked them out of it, and entered medical school because you wanted, above all else, to be a doctor. And when we use the word "doctor" we mean, of course, a physician.

If you entered the noblest of all the professions simply to make money or for the sake of personal aggrandizement, you are an almost negligible minority, and are to be pitied. Besides, it is not toward you that this article is directed. We are talking to the overwhelmingly large percentage of you who are doctors because, of your own free will and a natural pen-

chant, you elected to enter the healing art as your contribution to humanity.

It is reasonable to assume that you had at least the smattering of an idea, in advance of your matriculation, of the tremendous amount of work to be done with relatively few financial returns. It may be taken for granted that you were acquainted with a physician, or physicians, whom you knew and admired, and with whose work you had at least a nodding acquaintance. You knew these men to be honest, hard working and devoted to duty. You also had a wholesome suspicion that mental or physical laziness wouldn't get you very far in medicine.

Assuming you agree with us up to this point, and assuming further that you know how very much harder our fellow practitioners in the Service are working—for only a fraction of our emolument at home—and admitting that you are quite tired at the end of a long day, the question we would like to ask is: What the heck are YOU kicking about?

We rarely enter the elevator at the end of office hours, and ask a physician acquaintance how he feels, than he immediately pulls a long face and groans: "I'm tირred"! Several of these chaps found it none too easy getting a start only a few years ago. Today they have big practices, but constantly complain of how many patients they were FORCED to see before calling it a day. They are good men and deserve the success they have attained, but their attitude seems to us very much like looking a gift horse in the mouth. Personally, we are very grateful for being kept busy and for possessing a long memory. Not so many years ago we got very, very tired—WAITING for business!

We once knew a most successful quack who, because of a certain charm and a lot of ready—if misdirected—energy, amassed a tidy sum. We have no desire that you emulate his tactics, but on one point, at least, he was psychologically sound. Having two male assistants and numerous office nurses and technicians, he had but one rule which he insisted upon being followed to the letter: **No one must ever admit that he was tired.** He said it had a demoralizing effect on his patients, and quoted that classical definition of a bore: "A bore is one who, when you ask him how he feels, tells you!"

So you are tired, eh? Yow Yummm.

J. Phil. Edmundson, M. D., in Jackson County Medical Society Bulletin.

PENICILLIN ADMINISTERED BY MOUTH

British observers, according to The Journal of

the American Medical Association for April 14, have found the administration of penicillin by mouth with sodium bicarbonate and egg to be satisfactory in cases of tonsillitis. In an editorial The Journal states that the method is now on trial in the treatment of gonorrhea, pneumonia and surgical sepsis.

Because penicillin is sensitive to acid and alkaline reaction and is easily destroyed by the gastric juices of the stomach, its effective administration by mouth has presented difficulties. Its rate and degree of absorption in the body can be measured by the absorption of penicillin in the blood and the amount of penicillin excreted through the kidneys into the urine.

The Journal says that simplified methods of administering penicillin that will provide adequate and prolonged blood concentrations are being sought by many investigators. Crystalline penicillin has been combined with human plasma proteins for muscular injection. Penicillin has been given by mouth with trisodium citrate which eliminates the destructive action on penicillin by the hydrochloric acid in the stomach.

Now, The Journal says, "in a volunteer with gastric hyperacidity (an excessive amount of acid in the stomach) the most satisfactory excretion of penicillin in the urine occurred when he was given alkali, sodium bicarbonate, followed by penicillin mixed with raw egg. Three other volunteers received this mixture with successful results. The same dose of alkali and egg penicillin was given to a patient with achlorhydria (absence of hydrochloric acid in the stomach) to test the possibility of destroying the action of penicillin by over-alkalization. In this patient also the urinary excretion of penicillin was normal. Early tests on volunteers and patients showed that when 20,000 units of penicillin was taken orally the proportion excreted in the urine was 75 to 80 per cent, which is much the same as for the intramuscular administration of 15,000 units. * * *"

RANDOM THOTS OF THE SECRETARY

March 30th. With the coming of Amis, general gaiety is promoted in great fashion by a trip to Burns Gables, this organization fortunately in a position to furnish chicken livers, the Commander's favorite entree.

March 31st. Recorded as the ultimate in something or other—the suicide who shot herself in the abdomen keeping Hoge up all night closing perforations and combating shock, who then most unexpectedly went into grand mal, pushing Hoge's emotions to the brink.

April 6th. After forty-eight hours of unusually severe prodromal symptoms, disturbing in great degree to us

with our limited pediatric knowledge, the youngster shows characteristic papules of varicella, relieving us of much anxiety and Jones of the woes incident to treating parents as well as child.

April 10th. Forgetfulness on the part of the state secretary may be pardoned but when the county society secretary overlooks the meeting, as did Goldstein, it seems that Jones has a legitimate kick when forced to address mostly strangers.

April 11th. Memo to the Office of Defense Transportation: Maybe those Jefferson Day dinners are not conventions but we cannot see the difference.

COMMUNIQUE

To the Editor:

Received November, December, January and February copies of "Random Thots" on March 25th along with a stack of other mail. It is really swell to get these letters from you back home. I am writing so you may have my present APO number.

After spending quite some time in Australia, I am now Somewhere in the **. So far I have been unable to locate any of the medicos I know over here from Arkansas.

Thanks for all the past copies of "Random Thots" and we'll be expecting more in the future.

Sincerely,

Robert L. Turnbow, Capt., M. C.

FELLOWSHIPS FOR POSTGRADUATE STUDY AT HARVARD MEDICAL SCHOOL

Harvard Medical School, 25 Shattuck Street, Boston 15, Mass., is prepared to accept in its Courses for Graduates applications for registration as follows:

1. Medicine, October, 1945.
2. Obstetrics, any month, 1945.
3. Pediatrics, May 28-June 9, 1945.

A limited number of fellowships for these refresher courses are offered by The Commonwealth Fund, Division of Public Health, 41 E. 57th Street, New York 22, New York, to physicians who do general practice in rural areas in the State. Fellowship awards are made on the basis of information furnished by the applicant on forms obtainable from the Commonwealth Fund, and after a personal interview with a member of the Fund staff. Preference will be given to graduates of Class A medical schools and to those under 55 years of age. A fellowship entitles the recipient to reimbursement of tuition cost, necessary travel expense to and from Boston, and a stipend of \$250 for courses (1) and (2) above and \$125 for course (3) above.

PROCEEDINGS OF SOCIETIES

The Sebastian County Medical Society was addressed April 10th by I. F. Jones, "Toxemias of Pregnancy." D. W. Goldstein, Secretary.

The Southeast Arkansas Medical Society was addressed at McGehee March 19th by William W. Graham, Hot Springs National Park, "Late Penicillin Treatment of Venereal Diseases"; Mr. John Taylor, Little Rock, "Expanded Malarial Control Program in Arkansas," and E. J. Easley, Little Rock, "Prevention of Congenital Syphilis." C. W. Dixon, President.

Jefferson County Medical Society has elected the following officers: President, C. B. Capel; vice-president, J. S. Spillyards, and secretary; treasurer, Harold J. Morris.

The Craighead-Poinsett County Medical Society met in dinner session April 5th for a program as follows: "Arkansas Field Army Cancer Campaign," Mr. Eugene Barton, Jonesboro, and "Medical Aspect of Survival," Lt. Comdr. W. D. Snively, Newport Air Base.

J. H. McCurry, Secretary.

COMING MEDICAL MEETINGS

First Councilor District Medical Society, Jonesboro, May 15th, 6:30 p. m.

COMMUNIQUE

March 14, 1945.

To the Editor:

January "Random Thots" arrived again the other day, delayed, no doubt, because of my change in address. Please note and have it changed as I thoroughly enjoy these editions. Noticed in the last one where my roommate, C. G. (Toots) Leverett, is back in God's country. I've been looking all over ** for him over here. I can now understand why I haven't found him. Please drop him a line giving my address and tell him I want to hear from him. I've been in this one spot for the past three months. Of course, can't say how much longer will be here. Guess only our Lord knows, and just like the Army, He don't tell me secrets. Expect to wake up some morning in the CBI theater.

Thos. S. Van Duyn, Capt., M. C.

PERSONALS AND NEWS ITEMS

Elizabeth Fletcher Dishongh, Little Rock, has been appointed Lieutenant, Medical Corps, Naval Reserve, and assigned to the Memphis Naval Hospital.

H. King Wade, Jr., is now associated in practice with his father at Hot Springs National Park.

Virgil Payne, Pine Bluff, visited the Mayo Clinic during March.

Lt. Paul T. Stroud, Jonesboro, is now stationed at the Naval Receiving Station, Orange, Texas.

BORN—On April 2nd, a son, Steve Wayne, to Capt. and Mrs. Ewing M. Nixon, Little Rock, now stationed at Kennedy General Hospital, Memphis.

Lt. Alvin W. Strauss, Jr., Little Rock, is now stationed overseas with a combat engineer battalion.

Lt. Col. James W. Branch, Hopè, has received the Croix de Guerre for "exceptional services of war rendered during the course of the operations of the liberation of France." Col. Branch has also been awarded the Purple Heart for wounds sustained.

Drs. Reid and Barnett have purchased the Townsend Hospital at Arkadelphia.

Capt. C. L. Hyatt, Little Rock, has received the Bronze Star for gallantry in action in the European theater.

OBITUARY

WILLIAM C. KING, age 67, died at his home in Helena March 27th after a prolonged illness. Born in Henderson, Kentucky, he graduated from Memphis Hospital Medical College in 1901 and had practiced at Helena since graduation. He was a fellow of the American Medical Association and had served as president of the Phillips County Medical Society in 1944. Surviving relatives are several nieces and nephews.

For Our Country

LT. HIRA CHRISTOPHER BAKER, JR., Garfield, lost his life as the result of sinking of the

USS Hull near the Philippines on December 18, 1944. Born at Garfield, Arkansas, May 17, 1916, he graduated from the University of Arkansas in 1937 and from the University of Arkansas School of Medicine in 1942. He entered upon naval service July 10, 1943, after an internship and was assigned to the USS Hull September 14, 1943, serving aboard this destroyer until its sinking. Surviving relatives are his father and mother.

Dr. Baker is the second member of the Arkansas Medical Society to lose his life in World War II. The Journal is privileged to publish a letter from the commander of the USS Hull to Dr. Baker's parents:

"It is with deepest sorrow that I, as Commanding Officer of the USS Hull, write to you concerning the loss of your son, Hira Christopher Baker, Jr., who, following capsizing and sinking of that vessel on 18 December, 1944, was listed as missing at sea. I deeply regret to inform you that a careful review of the circumstances has led to the conclusion that there can be no hope that he survived.

"The circumstances surrounding the disaster in which his life was lost are as follows: The Hull was carrying out a war mission in company with a large group of naval vessels, which included the ill-fated Spence and Monaghan. There was little warning of the vicious typhoon which struck us with great violence. All precautions had been taken to secure the ship for heavy weather and she took a terrific beating from the typhoon before going down. The seas were mountainous and the wind which finally caused our capsizing was estimated to be about 110 knots, an unbelievably high velocity. Every maneuver was tried to improve our situation, but it was of no use; the storm had the ship in its grip. The order to put on life jackets was given in plenty of time to allow the crew to be ready for the disaster which occurred shortly after when the wind laid the ship slowly over on her side and the seas came flowing into the pilot house itself. There was ample time for the men to abandon ship, as she went down slowly. The mountainous seas pounded us with terrific violence. That any of us managed to come through it alive was a miracle, for I fully expected to be drowned within twenty minutes after I entered the water myself. It was quite impossible to see more than a few feet while in the water as the air was full of foam and spray, and we were spun over and over by the heavy waves.

"Extensive and careful searches were made the following days by both surface vessels and aircraft for survivors of the disaster. Since there

was no land within several hundred miles, it is quite impossible that anyone could have survived unless he was picked up.

"During the two and a half months that I served aboard the Hull it was my good fortune to know your son quite well. We had many long talks together and from them I learned a great deal of medical science, forming the opinion that your son was a most able medical officer. He was always extremely conscientious in his duties aboard ship and I am sure that the entire crew of the vessel would join me in expressing their appreciation for his sincere efforts toward their health and welfare. After entering the water when the ship sank I did not see your son at any time but it is my sincere belief that he was drowned in the raging sea.

"The knowledge that your son lost his life in the service of his country fighting a war against brutal and unprincipled enemies must be of some consolation to you in your great loss. Those of us who were fortunate enough to survive will continue to the best of our ability to attain victory. Please accept my sincerest sympathy in your sorrow and know that I shall be glad to be of any possible assistance.

"Very sincerely,

"J. A. Marks, Lt. Comdr., USN."

NEWS LETTER

March 1, 1945.

Washington Forecast

Introduction of the Wagner bill may be expected almost any time now. However, rumor says Senator Wagner may not present his measure until after President Roosevelt makes a special report on the health of the nation that is said to be scheduled now that he has returned from the Big Three Conference.

Watch development of S. 191—the Hill-Burton bill authorizing a national survey of hospital facilities and providing for the construction of hospitals—special attention is called to the sections of this measure having to do with the establishment of health centers. Hearings on this bill started February 26 before the Senate Committee on Education and Labor. This legislation is sponsored by the American Hospital Association and has been approved in principle by the Board of Trustees of the American Medical Association. Opinion is that this is the first real scientific approach by means of national legislation toward the problem of the distribution of medical care, where the need can be shown.

Significant point: control is left in the hands of the local communities.

Also look for continuation of the hearings of the Subcommittee on Wartime Health and Education of which Senator Claude Pepper is chairman. Many, many more hearings are expected before Senator Pepper and his committee may be ready to recommend legislation. Apparently this committee really is attempting to obtain best possible medical opinion before making final recommendations. If you have not already done so, read the Interim Reports of this Subcommittee on Wartime Health and Education, particularly the third (released some time ago) and the fourth report (released February 26). Copies of these reports may be obtained by writing your senators or congressmen.

These reports are a far cry from the same old compulsory federal sickness insurance that the Social Security Board has offered as its only answer to the medical care problem.

Fortnightly News Letter

This is the first of a series of biweekly news letters which you as a doctor who is interested in medical economics, and public relations will receive from the Council. These biweekly letters are intended to be timely, informative, objective, readable. To those who are maintaining public relations on the home front, the Council hopes by these letters to provide information as to what is new in the medical-economic field.

Prepayment Plans

Prepayment medical care planning is receiving much attention now. Iowa's House of Delegates approved a non-profit service plan at a special session several months ago and is working out a detailed plan; the Council of the Ohio State Medical Association has approved the formation of a stock indemnity company by members of the state society. Write to Dr. Robert E. S. Young, who spoke at the last A.M.A. Secretaries' Conference, or to Charles Nelson, the executive secretary of the Ohio State Medical Association, for details. Dr. Young's address is 9 Buttles Avenue, Columbus, Ohio. Charles Nelson's address is 79 East State Street, Columbus, Ohio. Connecticut is working on a plan and a detailed announcement may be expected. After a vigorous session at the special meeting of the House of Delegates of the Indiana State Medical Association, the House voted (1) to "approve a plan"; (2) to approve "an indemnity plan"; (3) to have a committee appointed to bring in a definite indem-

nity plan at a second special meeting of the House of Delegates, for final approval or rejection. A committee of twenty-one has been appointed and is at work on a plan.

A visit to Michigan Medical Service in Detroit provides an adequate idea as to the "big business" involved. Dr. A. S. Brunk, president of the Michigan Medical Society, and Jay Ketchum, executive vice-president of Michigan Medical Service, will supply information. (Soon we'll send a comparative chart, drawn up by the Iowa group, giving in handy form some details in regard to various plans.)

Physical Fitness Program

This is one of the important subjects in the 1945 medical program. Leadership should be in the hands of the profession. Special committees on physical fitness have been appointed by some societies. Watch for details in the A.M.A. Journal.

This subject of physical fitness is spotlighted as a result of the statements that 4,000,000 Americans were classed in 4-F by Selective Service. And this figure is being used by advocates of the federal control of medicine as a reason for the socialization of medicine. Joe Lawrence, Director of the Washington Office of the Council on Medical Service and Public Relations, suggests that all interested obtain the two pamphlets covering the "Hearings" of the Pepper Committee, officially entitled, "The Subcommittee of the Committee on Education and Labor, United States Senate, Upon Wartime Health and Education." (These are different from the Interim Reports.) Write your congressmen for these pamphlets, Part 5 and Part 6. Your attention is especially called to statements by Surgeon Generals McIntire and Parran, and Colonel Rowntree in regard to those rejected for military service. Dr. R. L. Sensenich, one of the A.M.A. representatives on the National Physical Fitness Committee, says that this 4,000,000 figure must be broken down to get the true slant on the situation. For the breakdown of these figures, see the July 22 and subsequent issues of the A.M.A. Journal.

As new things develop in medical economics or public relations in your county or state write them to the Council. What you are doing may help the other fellow solve his problems.

Council of Medical Service and Public Relations of the American Med. Assn.

COMMUNIQUE

Veterans Administration Facility
Alexandria, La., 23 March 45.

To the Editor:

This letter is to give you my opinion anent a recent article that appeared in a current magazine (Cosmopolitan, March, '45) in regard to Veteran Administration Facilities. As you well know I have had a long experience in the practice of medicine; in the field with troops; in the Station Hospital at Camp Chaffee, and for the past nine months in the tubercular service of the Facility at Alexandria, Louisiana.

Of course, isolated examples can be found both in Army set-ups and in Veteran Facilities where both errors of commission and omission have occurred, but to pick them out of all the volume of good work and medical care to a great number is a rank and unwarranted criticism. Since a large number of Arkansas patients are treated here I want to ask that you give some publicity to the Arkansas doctors to the end that they may know what we are doing and trying to do in the Veterans Administration Facilities to furnish medical care to veterans. I am only speaking from my personal observation during a rather short experience with tubercular patients but I feel that the same conditions prevail in all the other fields of medicine as practiced in the Facilities.

The writer's first italics are: "Yet one patient in six ever leaves these beautiful buildings labeled as 'cured.'" To answer this I feel that any doctor, or layman for that matter, realizes that the term "cured" can rarely, if ever, be applied to a tubercular patient. He fails to say that many do leave as "apparently arrested," "inactive" or "maximum hospital benefit." Parenthetically, I would like to say that cases treated by pneumothorax, thorocoplasty, pneumoperitoneum or other surgical procedure are never termed as "cured" but many, many cases are and will be sent home to a useful life after these measures have been instituted, and in many of these cases of pneumothorax the patient is taken care of after leaving the hospital as Out Patients or their refills are given at Government expense by qualified chest specialists. It is my observation that more and more of these early cases we are getting out of World War II will be sent back to their place in society rather than remain for numberless days and months in a tubercular hospital. The above statements also reply to some extent to the author's second statement in italics that "only three out of five complete their hospitalization and win

even the label of 'improved.'"

As for the Italicized line saying "The rest die or are discharged as 'improved,' or run away to other hospitals, or to suffer and die quietly at home" let me say first that Veteran Administration Facilities do not have the "military hold" on patients that the Army has and cannot force patients to take adequate time for treatment. Full well does Dr. Riley know that at Booneville where he has done such outstanding work against odds (lack of funds and lack of public cooperation) that tubercular cases are noted for leaving too early and come back only to bring with them a worn out and hopelessly unserviceable human machine.

Now as for the professional staff, let me say that from experience in private practice, in Army installations and in Veteran Administration Facilities, that there is little to choose. There are, of course, good doctors and bad doctors, humane physicians and tyros, interested and disinterested physicians, in all parts of the medical profession, but from my observation the staffs at the Facilities are every whit on a par with the Army or civilian groups. To say that the Army gets all the cream of the profession is ridiculous since they took physicians fast and loose as you well know in your work as procurement officer. It is my simple opinion that all the Facilities with which I am familiar are staffed well and are doing the utmost for the ex-soldier, ever realizing that he and only he is the sole reason for the existence of such hospitals.

To be sure there are faults and many of them. There are faults in human religion as manifested by its many sects; there are faults in our governments as witnessed by many wars; there are faults in our family structure as shown by the records of our divorce courts, and even if we give our own selves a little scrutiny we might find hidden faults. However, the most glaring faults of the Veterans Administration Facilities as I see them are due to a huge influx of World War II invalids coming in on Facilities that are not large enough to house adequately all of them at a time when doctors, nurses, orderlies and other necessary employees are scarce. Even at that the care given on the whole is excellent and "individualizing" of the patient is carried out as well if not better than at Army or private hospitals.

I am not nor would I be bold enough to give you any unauthorized figures as to the work of the Facility here but as a matter of fact figures can be made to show almost any angle favorably when they are properly juggled. This much

is certain, however, that any figures given as to the number of cases treated and the results therefrom should be divided sharply between World War I and World War II veterans. The veterans of 1917-18 are reaching an age when they normally are running out life's span and come to the veterans' hospitals for the usual chronic ailments that test the physicians' art both in private and hospital practice. Certainly the figures in cases of that age group should be considered as separate and apart from the steady stream of World War II veterans now coming in. As for the young tubercular veteran a great deal is being done and I feel that accurate statistics on their treatment will compare favorably with any other hospital or group.

Referring to the back-handed slap that the writer of the article takes at "the beautiful buildings" I feel that no one in his right mind would take away from our hospitalized men of war the quiet and excellently kept environments on which managers of these Facilities have given so much thought and time. The shaded, trim and flowered grounds are a restful and useful auxiliary in promoting cure and taking the sting out of hospitalization. This should not be argued and anyone with a sense of the fitness of things would dare not change them, and in their place erect sornber, austere and bleak hospital buildings.

Finally in spite of the large and ever increasing stream of sick veterans; in spite of the as yet unexpanded Veterans Facilities to take care of the new load; in spite of war created shortages of doctors, nurses and civilian employees, it is my honest and sincere conviction that the "last echelon" in the evacuation of the sick and wounded is doing its part as well as the "first echelon," or any intermediate station, and that, as a result, the American soldier is by far the best cared for of any Army that ever went forth to battle.

Cordially yours,

Stanley M. Gates, Maj., M. C.

COMMUNIQUE

U. S. Naval Hospital,
Memphis, Tennessee,
March 19, 1945.

To the Editor:

Twenty-three months on a bucking, bouncing tin-can left me in a most receptive mood for state-side duty. The Pacific ocean is quite vast and we sailed through it from the Bering sea north to the Coral sea south, from the West Coast to the Philippine seas in the east. In this period and in the various ports of the Pacific ocean, we took active part in 12 invasions, some 20 bombardments and six surface engagements,

including the battle for Leyte Gulf. I almost met my Waterloo in Leyte Gulf, but now am well recovered from the external wounds. I am hoping for at least a year of duty at this nice hospital.

I've been on the surgical staff here for the past month and a half. Drew Agar is indoctrinating the Navy to another of those rare species—AGAR.. George Russel, class of '41, is on N-P service here (no, not a patient, yet!). The staff consists mostly of good Southern gentlemen and a few pretty nice Yankees.

Hear from Mazzanti often. He was wounded a few days before I was at Leyte and is now in the hospital at Brigham City, Utah. P. R. Anderson is with an evacuation hospital in the Seventh Army.

Neil Compton reported in the other day and is assigned to the dependents clinic in Memphis. Think he was on Espiritu Santos before coming to our hospital.

While overseas I certainly enjoyed the "Random Thots" and The Journal. Everyone on board looked forward to "Random Thots" after the marvelous skit, "looks like someone tore off a piece."

I hear you are shy a Guinea Gold. Enclosed is one that I had stuck away (around a bottle of Australian beer). Don't know who wants it but send it on for the last word I got the little paper had been referred to before.

Please send The Journal and Thots to the above address.

Sincerely,

John M. Hundley, Lt., M. C., USNR.

WOMEN'S AUXILIARY NEWS

Mrs. Davis W. Goldstein will head the Auxiliary of Sebastian County Medical Society for the next year, succeeding Mrs. B. L. Ware. Auxiliary officers were elected April 9th.

The slate of the nominating committee, comprising Mrs. W. F. Rose, Mrs. Charles T. Chamberlain and Mrs. Walter G. Eberle, was approved unanimously when presented. Officers are Mrs. Davis W. Goldstein, president; Mrs. B. L. Ware, outgoing president, automatically becomes vice president; Mrs. M. E. Foster, secretary, succeeding Mrs. S. P. Stubbs; Mrs. Walter G. Eberle, treasurer, re-elected.

Mrs. Everett Moulton was hostess for a luncheon meeting. Mrs. B. L. Ware presided at the business session and election of officers.

Mrs. C. G. Leverett was a guest. Members present in addition to the hostess and newly elected officers were Mrs. J. S. Southard, Mrs. S. P. Stubbs, and Mrs. M. M. Even.

Mrs. W. F. Rose, Publicity Chairman.

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THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY
VOLUME XLI

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BIRTH REGISTRATION CAMPAIGN

Governor Laney has proclaimed May 1, 1945, as Better Birth Registration Day in Arkansas and urges persons and groups to cooperate with the State Health Department in their plans for observance of the day.

For some time May Day has been traditionally children's day, and in the past few years May Day programs have emphasized some phase of child health. Immunization against diphtheria and smallpox was featured in 1942. Safeguards for the health of young workers was the theme in 1943. Teen-agers themselves met on May Day of 1944 to explore possibilities for improving health conditions in their own communities and homes.

The occasion for the choice of Better Birth Registration as the theme for May Day of 1945 in Arkansas was the shocking revelation in figures recently released by the Census Bureau of the fact that Arkansas has the lowest birth registration rate in the whole nation.

The rate of birth registration is only 75.9 per cent complete, which means that only three out of every four births are being registered.

The State Board of Health realizes its responsibility in the matter and will do all it can under the circumstances to correct the situation.

Physicians realize more than most that a person can suffer real hardship from the lack of a birth certificate on occasions when he must prove the fact of birth, time and place of birth, parentage, or other pertinent information obtained most conveniently from a birth certificate.

However, many adults who have undergone considerable inconvenience from the lack of a birth certificate, especially since the beginning of the war, are coming to realize the value of birth registration to the individual. These are probably being more careful than in the past about making sure that their babies have been provided with this "first citizenship paper." They doubtless realize, too, that a birth certificate filed at time of birth is a more valid legal document than one filed some years later.

Furthermore, persons and agencies concerned with the planning of child care programs are particularly aware of the value of complete and accurate figures as a basis for intelligent planning. With both viewpoints in mind, the Maternal and Child Health Division and the Bureau

of Vital Statistics in the State Health Department have assumed sponsorship of the May Day program and are appealing to all interested groups to cooperate with them in the use of this day for two projects related to Better Birth Registration.

One of these projects is the launching of a long-term educational program appealing for the protection of the interests of children by making sure that their births are registered promptly and accurately. Newspaper articles, bulletins, and posters will appear soon showing what having a birth certificate means to the individual.

The other project is directed toward picking up unregistered births of the past few years. The project has been streamlined, for the present, to include only the 1944 unregistered, with the hope that an intensive pick-up campaign for the other years can be planned in the future.

A special 1944 request-for-check form to be returned before May 15 is being distributed throughout the state with the greatest concentration being directed toward the problem groups and areas. The problem groups in Arkansas are, as would be expected, isolated whites and rural and urban Negroes, since in these groups there is less likelihood of a physician's attendance at birth. Thirty-six counties have a rate of below 75 per cent. Low income is an important factor in the total picture.

No one person or group is wholly responsible for Arkansas' low rate of registration. While the local registrar is the key person, he must have the help of parents, doctors, hospitals, nurses, midwives, the Bureau of Vital Statistics, and even the citizenry at large. We must all work together on this program to give all of our "little citizens" the paper which will enable them to claim their rights and privileges as citizens throughout life.

COMMUNIQUE

March 1, 1945.

To the Editor:

A note of thanks for membership card, arrived today. Hope it will mean more than a souvenir before the year is over. Get a great kick out of "Random Thots." Keep me on the list, please.

Thank you.

Jett Scott, Maj., M. C.

①

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